UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, JANE DOE 2, JANE DOE 3, JANE DOE 4, JANE DOE 5, JOHN DOE 1, REGAN V. KIBBY, and DYLAN KOHERE,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States; JAMES N. MATTIS, in his official capacity as Secretary of Defense; JOSEPH F. DUNFORD, JR., in his official capacity as Chairman of the Joint Chiefs of Staff; the UNITED STATES DEPARTMENT OF THE ARMY; RYAN D. MCCARTHY, in his official capacity as Secretary of the Army; the UNITED STATES DEPARTMENT OF THE NAVY; RICHARD V. SPENCER, in his official capacity as Secretary of the Navy; the UNITED STATES DEPARTMENT OF THE AIR FORCE; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; the UNITED STATES COAST GUARD; ELAINE C. DUKE, in her official capacity as Secretary of Homeland Security; the DEFENSE HEALTH AGENCY; RAQUEL C. BONO, in her official capacity as Director of the Defense Health Agency; and the UNITED STATES OF AMERICA,

Defendants.

Civil Action No. 17-cv-1597 (CKK)

PLAINTIFFS' UNOPPOSED MOTION FOR LEAVE TO FILE DECLARATIONS IN OPPOSITION TO THE GOVERNMENT'S MOTION TO DISMISS AND IN FURTHER SUPPORT OF PLAINTIFFS' APPLICATION FOR A PRELIMINARY INJUNCTION

Pursuant to Local Civil Rule 65.1(c), Plaintiffs respectfully request leave to file additional declarations in opposition to Defendants' motion to dismiss and in further support of Plaintiffs' application for a preliminary injunction.

On August 31, 2017, Plaintiffs amended their complaint and moved for a preliminary injunction to restrain Defendants from implementing the President's August 25, 2017 order that the military revert, on March 23, 2018, to the pre-June 2016 policy categorically forbidding military service by transgender individuals. *See* Dkts. 9, 13. In support of their motion, Plaintiffs filed declarations from military experts, among others. *See* Dkts. 13-3 to 13-15, 15-2 to 15-6. On September 14, 2017, Secretary of Defense James Mattis issued interim guidance (the "Interim Guidance"), which remains in effect until a final plan to implement the President's order is issued, on or before February 21, 2018.

On October 4, 2017, the Government filed its opposition to Plaintiffs' motion and moved to dismiss Plaintiffs' amended complaint for lack of subject matter jurisdiction. *See* Dkt. 45 ("Opp."). In support of its combined opposition and motion, the Government filed declarations discussing the President's order, Secretary Mattis's Interim Guidance, and their effects on Plaintiffs. *See* Dkts. 45-2 to 45-3, 46-1 to 46-6. Relying heavily on the newly issued Interim Guidance, the Government makes several factual assertions that Plaintiffs dispute. In particular, the Government asserts that transgender service members are not presently being subjected to unequal treatment under the Interim Guidance, *see* Opp. 2, 15-18; that the injury to transgender people who have not yet entered the military from the current accessions ban is not ripe because, under the Interim Guidance, that ban is "subject to the normal waiver process," *id.* at 9, 26; and that a ban on service by transgender individuals is justifiable because "some transgender individuals suffer from medical conditions that could impede the performance of their duties," *id.* at 31.

Plaintiffs seek leave to file the following declarations responding to the Government's assertions:

- **Declaration of Mark. J. Eitelberg, Professor Emeritus at the Naval Postgraduate School in Monterey, CA.** This declaration describes how the changes to the policies regarding military service by transgender individuals, even under the Interim Guidance, harm Plaintiffs because those changes prevent transgender service members from serving equally with their peers, impose substantial limitations on their opportunities within the military, and negatively impact their day-to-day relationships with co-workers and other service members. The declaration rebuts the Government's argument that the transgender service ban has no current effect on military operations or personnel.

- **Supplemental Declaration of George R. Brown, M.D., Professor of Psychiatry and Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine.** This declaration rebuts the Government's reliance on outdated diagnostic categorization from nearly thirty years ago to claim that a ban on transgender individuals serving in the military is justifiable based upon transgender-related medical conditions or treatment. It responds to Defendants' position that being transgender is a behavioral or personality disorder and states the contemporary medical position regarding gender identity, gender dysphoria, and transgender identity. This declaration also addresses the pre-June 2016 waiver process for people with gender dysphoria, refuting the argument that Plaintiffs' claims are speculative until a request for such a waiver is denied.

- **Supplemental Declaration of Eric K. Fanning, Secretary of the Army from May 18, 2016 to January 20, 2017.** This declaration describes how the changes to the policies regarding military service by transgender individuals, including under the Interim Guidance, harm Plaintiffs because those changes not only degrade the value of transgender individuals to those service members themselves, but also give license to their leaders and fellow service members to do the same. It rebuts the Government's assertion that the ban has no effect on military operations or personnel. It also responds to the Government's argument that waivers are available to transgender enlistees.

- **Supplemental Declaration of Deborah Lee James, Secretary of the Air Force from December 20, 2013 to January 20, 2017.** This declaration describes how the changes to the policies regarding military service by transgender individuals, including under the Interim Guidance, harm Plaintiffs because those changes create a class of service members that are on unequal footing with their non-transgender peers for reasons having nothing to do with their capabilities or past performance, and suggest that transgender Airmen are unworthy of their comrades' trust and support. This declaration also makes clear that any request for a waiver of the ban on accession of transgender individuals would be futile, rebutting the argument that Plaintiffs' claims are speculative until a request for such a waiver is denied.

- **Supplemental Declaration of Raymond Edwin Mabus, Jr., Secretary of the Navy from May 19, 2009 to January 20, 2017.** This declaration describes how the changes to

> the policies regarding military service by transgender individuals, including under the Interim Guidance, harm Plaintiffs because those changes will predictably lead to lost opportunities for naval deployment, training, and assignments based on concern about those individuals' impending ineligibility. This declaration also makes clear that any request for a waiver of the ban on accession of transgender individuals would be futile, rebutting the argument that Plaintiffs' claims are speculative until a request for such a waiver is denied.

These supplemental declarations from military experts address new issues raised for the first time by the Government, specifically rebutting its assertions regarding the effect of the Interim Guidance and the military's medical waiver process on Plaintiffs' standing and the ripeness of Plaintiffs' claims. Courts have granted leave in similar circumstances, where supplemental declarations would serve to refute the Government's factual descriptions or "to rectify confusion that the Government itself created." *Nine Iraqi Allies Under Serious Threat Because of Their Faithful Serv. to the United States v. Kerry*, 168 F. Supp. 3d 268, 280 (D.D.C. 2016). In addition, the information provided in these declarations is significant and highly relevant to core issues in this case. This Court's consideration of all such information is especially important where, as here, the evidence "bears on … the Court's jurisdiction." *Id.*; *Coalition for Mercury-Free Drugs v. Sebelius*, 725 F. Supp. 2d 1, 8 (D.D.C. 2010), *aff'd*, 671 F.3d 1275 (D.C. Cir. 2012). Indeed, the Government itself stresses this Court's "'broad discretion to consider relevant and competent evidence' to resolve factual issues raised by a Rule 12(b)(1) motion." Opp. 13.

Finally, there is no prejudice to the Government from granting leave here. Under this Court's scheduling order, the Government is already permitted to file a reply. Absent this Court's leave, however, Plaintiffs will have no opportunity to correct the record and to proffer evidence that the Government's factual descriptions of the effects of the Interim Guidance and of the medical waiver process are wrong and that the President's order presently inflicts irreparable harms that warrant injunctive relief.

For all of these reasons, Plaintiffs respectfully request that leave to file the attached declarations be granted. Plaintiffs' counsel has conferred with defense counsel regarding this motion, and Defendants do not oppose the motion but may seek additional time to file their reply once they have had an opportunity to review Plaintiffs' declarations.

October 16, 2017

Respectfully submitted,

/s/ Paul R.Q. Wolfson

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
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Plaintiffs,	)	
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v.	)	Civil Action No. 17-cv-1597 (CKK)
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DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	

SUPPLEMENTAL DECLARATION OF RAYMOND EDWIN MABUS, JR. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Raymond Edwin Mabus, Jr., declare as follows:

1. As set forth in my earlier declaration signed and dated August 29, 2017, I was part of a Working Group that comprehensively reviewed military policy with regard to transgender people serving across the service branches. It was based upon that review and the recommendations of that group that the Department of Defense announced in June 2016 that it would begin allowing transgender people to serve openly in the military.

2. As further set forth in that declaration, I am aware that in a series of announcements made on Twitter on July 26, 2017, and then again in a formal memorandum issued by the White House on August 25, 2017, President Trump announced the reversal of military policy stating that transgender individuals would no longer be able to serve in any capacity. The memorandum set March 23, 2018 as the date when military policy would revert to the pre-June 2016 policy whereby transgender individuals are subject to discharge upon disclosure of their transgender status.

3. Based on my experience in military personnel and operations, the recently announced policy change is presently causing significant harms to current servicemembers who have disclosed that they are transgender. Those harms are not speculative or future harms. They are current harms that prevent transgender service members from serving on equal terms with non-transgender service members and that impose substantial limitations on their opportunities within the military.

4. Consideration of the ways in which deployment decisions are made highlights the current limitations and lost opportunities being experienced by transgender service members. Consistent with naval operations, ships may deploy for up to 9 months at a time. Commanders making decisions about how to staff naval operations must consider the length of time that a sailor will be available for a deployment. If a sailor may not be available for the full length of a deployment, command knows that they will have to expend significant resources to backfill staffing needs in order to address the diminishment of resources. Rather than face those challenges, command will predictably make assignments based on certainty about sailors' ability to serve the full length of deployment.

5. Because of the announcement of the ban on transgender people being able to serve after March 2018, command lacks the requisite certainty that transgender service members will be able to complete the terms of their deployments where they extend beyond that date.

6. Similarly, command must regularly make personnel decisions that relate to "permanent change of station" (PCS) moves. PCS moves are made to ensure maximum utilization of personnel and to achieve military missions. PCS moves involve transporting service members and their families to a different base and duty station, often across the country or the world. The introduction of any uncertainty with regard to a service member's future

service, or status, changes command's consideration of PCS moves and military operations staffing. Based on my experience, the announced ban on transgender people serving is impacting PCS moves.

7. As a result of the announced ban, transgender service members are losing opportunities for assignments that they are capable of doing. These include lost opportunities for deployment, training, and assignments. These lost opportunities are based not on individual assessment of the service member's merit but rather based on whether the person is transgender. These lost opportunities, in addition to depriving transgender members of the military of the ability to serve on equal footing with their peers, hinder transgender service members opportunities for advancement and promotions as well.

8. The impact of this immediate harm reaches beyond the individual service member and affects the institution of the military as a whole. The military is designed to be a meritocracy where individuals receive opportunities and tackle assignments based on their ability to do the job. The institution is weakened when people are denied the ability to serve not because they are unqualified or because they cannot do the job but because of who they are.

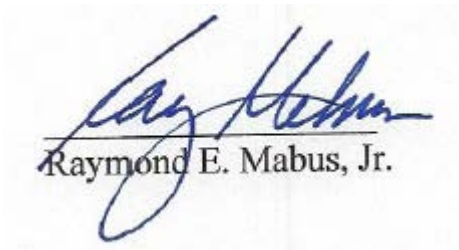
9. The ban on transgender service members weakens the military in a second way as well. With an all-volunteer force, which is the current structure of the military, a small segment of the population is responsible for the security of the whole. In this circumstance, it becomes even more important to have a diverse military in order to maintain a strong connection between those who serve to protect society and the society that the force is protecting. Banning a segment of the community from service weakens the bond of that connection between the military and society and sends a message that certain segments of the community are not within the scope of the mission. That message interferes with and diminishes military readiness and lethality.

10. Finally, based on my military experience and in my former role as Secretary of the Navy, I know of no instance where a Midshipman was allowed to complete their education at the Naval Academy where an individual experienced a condition which rendered them ineligible to commission into the Navy and where the Midshipman had two years remaining at the Academy.

11. In addition, I know of no instance either prior to June 2016 or since when a transgender person seeking to enlist was granted a waiver to the ban on service. In any case, it would be futile for a transgender person to seek a waiver to join the military at this point in time since, according to the announced policy, they would be subject to administrative discharge as soon as March 2018.

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

DATED: October 12, 2017



Raymond E. Mabus, Jr.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	

SUPPLEMENTAL DECLARATION OF DEBORAH LEE JAMES IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Deborah Lee James, declare as follows:

1. As noted in my prior declaration, I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017. As Secretary, I was responsible for supervising the Department of the Air Force's participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group").

2. Based on the Working Group's analysis and recommendations, the Department of Defense announced in June 2016 that it would begin to allow transgender people to serve openly in the Armed Forces.

3. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25,

2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. The President's memorandum stated that the military would return to the pre-June 2016 policy on March 23, 2018.

4. Based on my experience regarding military personnel, and in particular personnel and operations of the USAF, the President's announced decision to ban openly transgender people from serving in the military effective March 23, 2018 is presently harming transgender people currently serving in the military in several significant respects.

5. Airmen are typically deployed for periods of time that exceed several months, and planning for a deployment begins several months in advance of the deployment. Commanders in charge of overseeing deployments must take into account the certainty with which Airmen will be available for the entire length of a deployment when making assignment decisions.

6. Given the President's announcement that transgender service members will be subject to separation from the military beginning March 23, 2018, commanders cannot rely on transgender Airmen being able to complete deployments that continue beyond that date. Transgender Airmen with deployment terms that extend beyond March 2018 will thus lose opportunities for assignments because command will not be able to determine with certainty that transgender Airmen will be present for the entire duration of the deployment. In addition to negatively impacting individual Airmen, this uncertainty harms USAF readiness and capabilities where commanders are not able to make assignments based solely on the capabilities and experiences of those under their command.

7. Even outside the deployment context, transgender Airmen will lose out on assignments, opportunities, and experiences they would otherwise receive but for the President's

announcement that they will be subject to separation in March 2018. Commanders will be reluctant to invest time and money on training transgender Airmen for important or significant assignments or tasks where commanders believe the Airmen will be expected to leave the USAF in the near future.

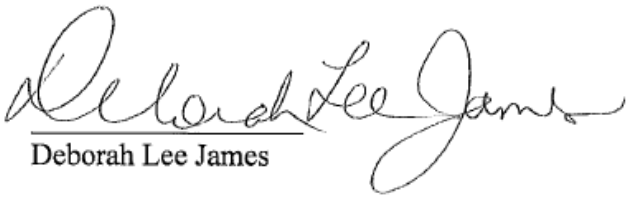
8. In addition, the President's announced ban on transgender people serving in the military creates a sub-class of service members, placing transgender people on unequal footing as compared to their non-transgender peers for reasons having nothing to do with their capabilities or past performance, and suggesting that transgender Airmen are unworthy of their comrades' trust and support. A lack of trust among service members is deeply concerning, as trust and respect throughout the chain of command is essential to promote military effectiveness. Thus, in addition to causing present harm to transgender Airmen, the President's ban will have a deleterious effect on the USAF's effectiveness and capabilities as well.

9. The President's announced ban is also anathema to the ethos of the military in general, and in particular the USAF. In the USAF, individual Airmen are given assignments and receive commendations and promotions on the basis of their individual merit and skill set. The USAF, and the military in general, are weakened when this fundamental building block of their identities is fractured through suggesting that service members should be judged based on characteristics having nothing to do with their ability to perform their job.

10. Finally, I am not aware of any instance – before or after June 2016 – where a transgender person seeking to join the military was granted a waiver to the ban on service of openly transgender individuals. Even if a transgender person were to seek a waiver at this time, doing so would be futile in light of the President's order making transgender service members subject to separation beginning in March 2018.

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

DATED: October 12, 2017



Deborah Lee James

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

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DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	
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SUPPLEMENTAL DECLARATION OF ERIC K. FANNING IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Eric K. Fanning, declare as follows:

1. As set forth in my earlier declaration signed and dated August 28, 2017, I oversaw the Department of the Army's participation in the Working Group that comprehensively reviewed military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

2. My earlier declaration also sets forth my awareness of the announcements of a new policy on transgender service, both through Twitter in late July 2017, and then in a Presidential Memorandum ("the Memorandum") issued by the White House on August 25, 2017. Although providing the Secretaries of Defense and Homeland Security the opportunity to review the current policies, the Memorandum sets March 23, 2018 as the date by which the June 2016

policy "shall" be reversed (section 3) and transgender individuals will be subject to discharge as a result of disclosure of their transgender status.

3. Based on my knowledge and experience in military personnel and readiness challenges, as a result of service as a senior executive in each of the three military departments as well as Chief of Staff to the Secretary of Defense, the recently announced policy change is causing significant harm to current servicemembers who have already disclosed their status as an individual who is also transgender to their commanders.

4. The Memorandum asserts that the "previous Administration" had an "[in]sufficient basis" for allowing open service, and therefore, this Administration is directing the reversal of policy changes that had enabled open service based on its "meaningful concerns" about the impact of open service on "under military effectiveness and lethality, disrupt unit cohesion, or tax military resources."

5. In my experience, this communicates that the Commander in Chief of the U.S. military believes that transgender service members are unfit for military duty solely because of their transgender status. It degrades the value of transgender individuals not only to those service members themselves, but gives license to their leaders and fellow service members to do the same, in an environment where the ability to unqualifiedly and mutually rely on each other is an indispensable element of service. The Memorandum on its face marks these service members as deserving of impending involuntary discharge.

6. The Memorandum alone, and certainly when animated by the President's tweets, causes harm by preventing transgender service members from serving on equal terms with other service members based on their merit; serves to substantially limiting their advancement and promotion opportunities in the military; and undermines their standing with superiors and peers,

as described above. Opportunity to succeed and advance in the military should not depend on gender identity, nor any other factor other than ability to meet the required standards.

7. The harm extends beyond the individuals involved to the whole ethos of the military as a meritocracy where all Americans who want to serve and can meet its standards should be afforded the opportunity to do so. Unjustified, categorical bans on Americans qualified and ready to serve diminishes that organizing principle.

8. Furthermore, the Presidential Memorandum and Secretary of Defense Jim Mattis' August 29, 2017 announcement that he will "carry out the president's policy direction" by "develop[ing] a study and implementation plan" sends the clear message to American society that the U.S. Army is not, as General Mark Milley, the Army's Chief of Staff and highest ranked officer, declared in 2016 "open to all Americans who meet the standard, regardless of who they are."

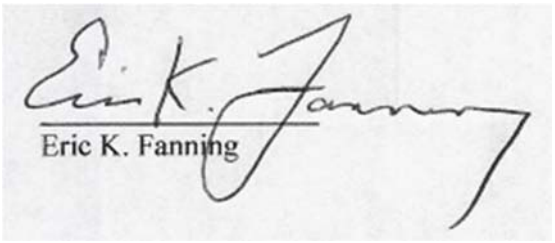
9. That declaration is essential to ensuring the military has access to the best and brightest America has to offer and that those who seek to serve know that they will be judged by their performance alone, rather than the artificial prejudices that once hampered the advancement and acceptance of African Americans, women, religious minorities, and gays and lesbians in our nation's armed forces.

10. In addition, when the military fails to keep pace with the demographic change of our nation and departs from the core principle of opportunity for all that can meet its high standards, it results in an erosion of understanding between those who serve and those who freedom those service members defend. The President's tweets and directive undoubtedly exacerbate this divide, both by creating a single class of Americans he deems unfit to serve and dividing the nation by telling them that only these individuals are unfit.

11. Finally, during my tenure as Secretary of the Army, I am unaware of any instance prior to or after June 2016 when a transgender person seeking to enlist or accept a commission in the Army was granted a waiver from the Army's medical accession standards.

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

DATED: October 15, 2017



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Defendants.	)	

DECLARATION OF MARK J. EITELBERG IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Mark J. Eitelberg, declare as follows:

1. I am a Professor Emeritus at the Naval Postgraduate School in Monterey, California. I have personal knowledge of the matters stated in this declaration and can competently testify to these facts.

2. I received a Master of Public Administration degree from New York University in 1973 and a Ph.D. in Public Administration in 1979, also from New York University. I joined the faculty of the Naval Postgraduate School as an Adjunct Research Associate Professor in 1982. I was tenured as an Associate Professor in 1995 and promoted to Professor of Public Policy in 1999. I retired from federal service in April 2017. Upon retirement, in recognition of my distinguished service, I was designated Emeritus Professor of the Naval Postgraduate School. I served with the New Jersey Army National Guard and the U.S. Army Reserve from 1970 to 1976, the last two years as Staff Sergeant.

3. My teaching and research at the Naval Postgraduate School focused on military manpower and personnel policy analysis and military sociology/psychology. Among my research interests are the following: population participation ("representation") in the military; the All-Volunteer Force; military force management and manpower policy; military manpower selection, classification, and utilization; and equal opportunity and diversity management. My honors include the Robert M. Yerkes Award (for outstanding contributions to military psychology by a non-psychologist) from the Society for Military Psychology, a division of the American Psychological Association, and the Department of the Navy Superior Civilian Service Award. I have served on the Board of Editors of the journals *Armed Forces & Society* and *Military Psychology*. I was Editor-in-Chief of *Armed Forces & Society* from 1998 through 2001. A true and correct copy of my curriculum vitae and a list of my publications are attached to this declaration as Exhibit A.

4. I am aware that, on June 30, 2016, the Department of Defense announced it would begin allowing transgender persons to serve openly in the military. As stated in the official announcement and news release (NR-246-16): "Effective immediately, service members may no longer be involuntarily separated, discharged or denied reenlistment solely on the basis of gender identity. Service members currently on duty will be able to serve openly." This change in policy followed a careful review by a comprehensive working group that included high-ranking uniformed and civilian personnel as well as medical experts and other highly knowledgeable persons. The new policy assured current service members that they could reveal their gender identity if they chose to do so. The policy also established procedures for transgender service members to receive appropriate medical care for gender transition. Subsequently, many

transgender service members informed their chain of command and their peers that they are transgender.

5. I am also aware that, in a series of informal comments on July 26, 2017, and later in a formal memorandum on August 25, 2017, President Donald Trump directed that the policy allowing transgender individuals to serve openly in the military "return to the longstanding policy and practice" that prohibited transgender persons from serving in any capacity. Up to this point, for over one year previously, transgender service members were told that the Department of Defense had "ended" its ban on transgender Americans serving in the U.S. military. Under this policy and a forthcoming implementation plan, transgender service members will once again be subject to discharge by the Department of Defense on March 23, 2018.

6. Based on my knowledge, experience, and research in the fields of military manpower and personnel policy, military sociology, and military psychology, the newly announced policy is significantly harming service members who have disclosed they are transgender. This is not merely a potential problem or future hardship due to the scheduled March 23, 2018 date on which they will become subject to being separated. The new policy prevents transgender service members from serving equally with their peers; it imposes substantial limitations on their opportunities within the military; and it negatively impacts their day-to-day relationships with co-workers and other service members.

7. Military service opportunities are generally structured through career tracking by occupational area within each separate service, with scheduled training and skill-level assessments, operational assignments (or tours) and deployments, windows for advancement, and increased responsibilities based on experience, time-in-service, conduct, and performance. At the same time, as with any occupation, discretionary judgments or decisions within a service

member's chain of command can have a strong impact on one's job opportunities or daily life. Naturally, these decisions are influenced by expectations regarding a service member's future in the military. From an operational perspective, commanders understandably are reluctant to invest significant resources in the training or development of individuals who might leave military service in the near future, or to entrust them with important assignments. This dynamic is similar to what occurs in other large organizations when an employee is known to be departing several months in advance. Transgender service members who informed others of their gender identity based on the government's pledge that they could serve openly as of June 30, 2016, believing that "ending the ban" would not be temporary, have no secure future in the military beyond March 23, 2018.

8. Transgender service members leaving military service would likely be held in their present duty location, pending a confirmed date of their involuntary separation. Lost opportunities and personal problems would ensue, particularly if the service member has a family, children in school, or other dependents. Previously scheduled training, deployment, change of duty station, or other planned career events would be canceled by the military to save related costs, minimize organizational disruption, and simplify discharge. Some of these service members would continue to work in their present positions until separation; others would be temporarily "stashed" in another work unit; and some might be placed in a "make-work" situation or "holding pattern" while awaiting separation. If the person has a particularly important skill, knowledge, or expertise, she or he may be asked to train a replacement. In other cases, an individual scheduled for discharge may be gradually relieved of duties or assignments as their responsibilities are delegated to others. Depending on the supervisor's views and management style, this might mean the person slated for discharge will be required to perform

tasks no one else wants or be assigned less challenging, repetitive tasks that do not enhance their skill development.

9. Such reductions in responsibility have an impact even on service members whose departure from the military is voluntary and who have begun to make plans for their post-military life. The impact is much more severe for those who had been planning to remain in the military but are unexpectedly facing the prospect of involuntary separation, because their accumulated efforts to excel or advance and their career aspirations essentially disappear upon discharge. The potential harm to these women and men economically is undeniable; added to this is the psychological distress of being told that their performance in service to the nation is meaningless when measured against their gender identity. They had volunteered to serve their country, to accept the associated risks, and to perform well and honorably. The military considered them qualified to serve when they joined. Surely, many would want to understand why their gender identity now makes them unqualified to serve their country, and to such a degree that they should be removed from the military.

10. The President's memorandum also harms transgender service members in another way. According to the memorandum, "the previous Administration failed to identify a sufficient basis to conclude" that terminating the ban on transgender persons "would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." Consequently, "meaningful concerns" remain regarding the "negative effects" of removing a ban on transgender persons. In essence, the President's directive reestablishes the *reasons* for prohibiting military service by transgender persons prior to the policy change of June 30, 2016, negating the conclusions of the comprehensive working group that supported removing the ban as well as any

training, guidance, regulations and forms, protocols, and supporting networks developed by the military to facilitate transition.

11. In reversing the previous policy, the President's directive instructs commanders and other service members that transgender individuals are detrimental to the military. No further explanation is provided, merely a statement that the present basis for concluding otherwise is insufficient. Although commanders would attempt to ensure that transgender personnel continue to be treated with dignity and respect, as emphasized in training, the President's directive to discharge transgender personnel erodes the value that members serving with them place on their contributions or performance. Reestablishing reasons for discharging transgender personnel legitimizes any bias or prejudice that may have existed among non-transgender members prior to training. As a result, transgender service members are being currently harmed and restricted artificially from being able to serve as equals with their peers.

12. In previous cases of involuntary discharge, service members slated for separation are viewed commonly as a nuisance and may be harassed by co-workers or treated differently by commanders prior to the member's departure. Additionally, as a service member approaches involuntary discharge, documented cases indicate that superiors may be less than complimentary in evaluating the member's performance, perhaps motivated to confirm the basis for separation. For transgender personnel facing involuntary discharge under the new policy, this could mean an unfairly low or negative performance rating rather than one based solely on merit. Consequently, the announced ban has the current effect of inducing conscious and unconscious bias among peers and commanders that ultimately harms transgender personnel by limiting their service opportunities and chances for advancement and promotion.

13. The President's memorandum identifies the potential disruption of unit cohesion as a key factor in reversing the policy of June 2016 and discharging transgender service members. Clearly, unit cohesion is a critical element in the military. Historically, this purported concern has been used to justify U.S. military policies of racial and gender segregation. More recently, unit cohesion served as a reason for the policy known as "Don't Ask, Don't Tell" (DADT). DADT itself stimulated considerable research by scholars to better understand unit cohesion and how it can be improved in the military. Previous studies have identified "task cohesion" (compared with "social cohesion") as most important in accomplishing a military mission. Strong bonds among service members are important in undertaking a mission and are particularly apparent in smaller military units, among persons on deployments, and among those who serve under dangerous conditions.

14. As noted, the President's directive places transgender personnel in a "holding pattern," subject to involuntary discharge on March 23, 2018. Knowing this, military commanders and co-workers are obviously less likely to bond with transgender service members and more inclined to keep them at a distance. Transgender personnel are thus more prone to be viewed as unimportant to a unit's cohesiveness and treated as such when working with their peers. Mutual trust and respect erode as co-workers see transgender personnel as "them," on the way out. Clearly, working relationships, as well social relationships, will suffer. Transgender personnel may feel isolated and alone. Added to this is the understanding among co-workers and commanders alike that transgender personnel are identified by the new policy as a potential detriment to military effectiveness and unit cohesion. Based upon current understanding of unit cohesion, the President's directive will damage the bond between transgender personnel and

their co-workers and thus disrupt the very unit cohesion that it seeks to protect. It also puts transgender troops in harm's way while serving, especially when deployed in active combat.

15. Being branded as disruptive or unworthy of service also carries consequences that are unique to the military context and differ from the dignitary harms suffered by those who face discrimination in civilian life. Military service is widely understood as an integral element of citizenship, and many regard it as a civic duty. Historically, the military has served as a path for members of minority groups, immigrants, and social outcasts to gain recognition as true and loyal citizens. When the military adopts a policy that degrades or demeans a group of service members, the message goes out to the larger society that such treatment is acceptable. This is especially observable during times when the military is held in high esteem by the general public. Indeed, according to annual Gallup polling, the U.S. military is "the most trusted institution" in the country. This has been true from 1989 to 1996 and from 1998 to 2017, with 72 percent of adult Americans presently expressing "a great deal" or "quite a lot" of confidence in the military. Barring individuals who are physically, medically, intellectually, educationally, emotionally, and morally qualified to serve based on a personal characteristic that is irrelevant to their ability sends a powerful message that the government distrusts or disapproves of the excluded group or sees them as unfit. African-Americans, Japanese-Americans, women, and gay and lesbian people once faced such official disapproval. Barring demographic groups from equal service gives them the overt stigma of civic inferiority.

16. Being labeled unworthy to serve also impairs service members' ability to carry out their duties safely and effectively. Since people serving in the military depend upon each other so much, particularly under life-threatening circumstances, being isolated or mistrusted can have enormous consequences. If others see someone in the unit as not being as of equal value,

they may not work as effectively with them or protect them as well as they would other unit members. And, unlike in civilian life, it is often difficult to escape the military workplace, which may be on a ship at sea, deployed overseas, or living on a base in close quarters with one's peers.

17. One final harm should be mentioned. The President's memorandum brands transgender personnel in a way that will follow them well into the future. Stained by the claim they are disruptive or damaging to a working unit's effectiveness—followed by their consequent separation from the military—transgender personnel may be irreparably harmed in finding post-service employment. Military recruiting advertisements often say that "it's a great place to start" and that military training and experience are invaluable to those seeking employment in the civilian job market. A natural result of the ban for transgender personnel is to diminish their opportunities for civilian employment following military service.

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

DATED: October 15, 2017

Mark J. Eitelberg

Exhibit A

Mark Jan Eitelberg, Ph.D.

Biographical Summary

Dr. Mark J. Eitelberg is an internationally recognized authority on military human resources policy and America's All-Volunteer Force. In April 2017, he retired from federal service as Professor of Public Policy in the Graduate School of Business and Public Policy, Naval Postgraduate School (NPS), Monterey, California. Upon his retirement, he was designated Emeritus Professor of the Naval Postgraduate School. In nearly 35 years at NPS, he taught courses in policy analysis, military sociology/psychology, and research methods. He advised over 250 Master's theses along with several doctoral dissertations. He held a number of administrative positions, founded and directed a research center, and served on the school's Institutional Review Board for thirteen years. Prior to joining the faculty at NPS in 1982, Dr. Eitelberg was a Senior Scientist with the Human Resources Research Organization (HumRRO), where he directed numerous studies, co-designed a GI Bill educational benefits program, and conducted groundbreaking research for the Department of Defense. Between 1976 and 2017, he directed more than 34 research projects for the Office of the Secretary of Defense and U.S. Defense agencies.

Dr. Eitelberg is the author or co-author of approximately 120 publications and professional papers. Over the past several years, his research and writing have focused on issues related to population participation in the American military, a subject treated in several works: *Military Representation* (1979), *Blacks and the Military* (1982), *Screening for Service* (1984), *Manpower for Military Occupations* (1988), *Becoming Brass* (1991), and *Marching Toward the 21st Century* (edited, 1994). More recently, he coauthored *Profiles of American Youth* (2013), a book on the results of a nationwide administration of the military's enlistment test.

Dr. Eitelberg has been a consultant with a number of government agencies, commissions, and private organizations. These include the Brookings Institution, the RAND Corporation, the Atlantic Council of the United States, The Technical Cooperation Program (TTCP, an international consortium of defense scientists), the Defense Equal Opportunity Management Institute, the National Defense University, the Center for Strategic and International Studies, UC-Berkeley's National Commission on Testing and Public Policy, Grey Advertising, Campbell-Ewald, and several publishers, among many others. He has served on two committees of the National Research Council (National Academy of Sciences). He is the former Editor-in-Chief of *Armed Forces & Society*, a leading scholarly publication and the official journal of the Inter-University Seminar on Armed Forces and Society. He is a recipient of the U.S. Navy Superior Civilian Service Award and the Robert M. Yerkes Award of the American Psychological Association (Division 19), for outstanding contributions to military psychology by a non-psychologist. In 2001-2002, he was a Visiting Scholar with the Office of Population Research, Woodrow Wilson School of Public and International Affairs, Princeton University.

Dr. Eitelberg is a graduate of Franklin and Marshall College, where he majored in Government and in Religious Studies. He holds an M.P.A. and a Ph.D. in Public Administration from New York University. He is a former professional artist and metal sculptor. He served with the New Jersey Army National Guard and the U.S. Army Reserve; his final assignment was senior training coordinator with a basic training battalion of the US Women's Army Corps (WAC), where he gained the distinction of being one of few "male WACs" in U.S. history.

Selected Career Highlights

- Early in his career at HumRRO, the Office of the Secretary of Defense (OSD) identified him as one of the nation's leading authorities on "GI Bill" educational benefits, including their importance to the continued success of the All-Volunteer Force (AVF). In May 1976, after President Ford proposed eliminating all GI Bill benefits for new service members, Eitelberg and two associates developed a compromise program to replace the GI Bill (on a napkin in the John Bull Restaurant in Alexandria, Virginia). The U.S. Senate Committee on Veterans' Affairs and OSD were chief advocates of the plan, which became the Post-Vietnam Era Veterans Educational Assistance Program (also known as VEAP). VEAP replaced the GI Bill for new recruits in January 1977; since then, nearly 800,000 veterans have participated in the program. Eitelberg subsequently assisted OSD in further defining its educational benefits policy; he also developed and co-authored four OSD reports to Congress on VEAP, an experimental program with several innovative features.

- In 1976-1977, the US Army Research Institute for the Behavioral and Social Sciences (ARI) asked Dr. Eitelberg to study population representation in the military, a subject of heated debate prior to the end of the draft. Within a year, he became a national authority on the topic. Bernard Rostker, in his epic history of the AVF (*I Want You!*, RAND, 2006), writes: "Possibly the most rigorous assessment of representativeness came in a 1977 report by Mark Eitelberg of the Human Resources Research Organization for the Army Research Institute." This assessment laid the foundation for Eitelberg's doctoral dissertation at New York University (1979). The Brookings Institution subsequently hired Eitelberg for its Associated Staff, and his dissertation research contributed importantly to a Brookings Study in Defense Policy, *Blacks and the Military* (Binkin & Eitelberg, 1982).

- *Blacks and the Military*, by Martin Binkin and Mark J. Eitelberg, became an instant "best-seller" for Brookings, since it was the first study of its type and it addressed a topic that was of increasing interest to many. The day after publication, the book's major findings appeared in well over 350 newspapers and other periodicals throughout the world—as well as in all US television network news shows. A *Washington Post* Sunday Book Review featured the book. Coverage later appeared in newspaper editorials, syndicated columns, and in various news and opinion magazines. Binkin was interviewed on NBC's *Today Show* and on several other national television news outlets, such as CNN. Eitelberg, the shy one, declined numerous invitations to appear on popular network television and radio talk shows, including *The Larry King Show*. Many now refer to the groundbreaking book as a "classic" of its genre.

- Eitelberg's work on population representation in the military led to many other opportunities. By the early 1980s, OSD considered Eitelberg their "go-to authority." He presented papers and wrote extensively on the subject. He ghost-wrote reports to Congress, including several of OSD's annual reports to Congress on population representation in the AVF. In the mid-1980s, OSD asked him to redesign the annual representation report. He developed new statistical indicators and recommended that women be included as a primary focus in the report; apparently, no one had noticed that women were missing entirely from the document up to that point. Soon after Operations Desert Storm/Desert Shield concluded, OSD commissioned Eitelberg to write the official history of population participation in the first Gulf War. Many of Eitelberg's innovations and approaches to studying representation are still used by DoD and continue to appear in their annual report decades later. His expertise on population participation in the military also led to extensive research and writing over the years on equal opportunity, population diversity, gender and minority integration, and other related topics. He consulted

often with the Defense Equal Opportunity Management Institute and with a number of organizations in OSD. He worked closely with the Defense Advisory Committee on Women in the Services and with various government commissions on integration and equal opportunity. He advised over 100 Master's theses, a few doctoral dissertations, as well as dozens of student projects on population diversity themes. He was also the only person invited to present a paper (later two book chapters) at both DoD conferences celebrating anniversaries of America's All-Volunteer Force (convened at the US Naval Academy in 1983 and in 1993).

- In the 1980s, Eitelberg also established himself as a national authority on the selection and screening of applicants for military enlistment and commissioning in the officer corps. He was a primary author of DoD's study of national testing data. Publication of the final report, titled *Profile of American Youth: 1980 Nationwide Administration of the Armed Services Vocational Aptitude Battery* (1982), was covered widely by the national media, including *The Washington Post*, where it became the lead story on the front page of a Sunday edition. Eitelberg used Profile of American Youth data for a co-authored book, *Screening for Service* (1984), and a single-authored book, *Manpower for Military Occupations* (1988), which became a "minor classic" among scholars in the field. In 1989, with funding from the National Commission on Testing and Public Policy (UC-Berkeley), Eitelberg led a team of researchers in studying the testing and selection of U.S. military officers. He produced the first (and only) study using the SAT scores of military officers. When the results were published initially in *Becoming Brass*, the *Navy Times* reported the findings in a cover story, "Brains on Board," along with several related articles. Years later, Eitelberg was invited to coauthor a DoD study of the second Profile of American Youth, administered to establish new scoring norms for the military's enlistment test. This resulted in a 300-page, book-length manuscript, *Profiles of American Youth: Generational Changes in Cognitive Ability* (2013), after years of effort.

- Many scientists and policy analysts over the years have used Dr. Eitelberg's "Population Representation Model," which he developed in the late 1970s. This includes scholars and practitioners from around the world (including the governments of Australia, Canada, New Zealand, and the United Kingdom), the Congressional Budget Office, the Government Accountability Office, the U.S. military services and DoD, among many others. Most recently, his model has served as a central organizing theme in several Master's theses at NPS: two students (individually) from Turkey and students from Greece, the Republic of Korea, and Germany. The model holds a universal appeal for scholars internationally, and Eitelberg often presented seminars on the model for visiting international dignitaries and defense leaders through the NPS Center for Civil-Military Relations (CCMR).

- In 1992, as part of the "Army Futures" project, Dr. Eitelberg and his colleague, Dr. Stephen Mehay, organized a two-day, major conference in Arlington, Virginia. The conference, chaired by Dr. Eitelberg, featured over 20 speakers, including senior officials from the U.S. Army and Department of Defense, distinguished scholars, and subject area experts from several government agencies. The conference resulted in a book, *Marching Toward the 21st Century*, edited by Eitelberg and Mehay for Greenwood Press (1994).

- Eitelberg has assisted many organizations and groups, as noted elsewhere. Among the most significant are ten years of service (several appointments from 1990 to 2001) as a DoD representative on The Technical Cooperation Program (TTCP), an international consortium of defense scientists. Additionally, he served on two committees of the prestigious National Academy of Sciences, both of which resulted in the publication of a committee-authored book.

Dr. Eitelberg also served for nearly 13 years on the NPS Institutional Review Board (IRB). No one has served longer on the NPS IRB.

- In 1998, Eitelberg was Faculty Team Leader and U.S. Chair for a two-day conference in Moscow. Over 100 senior leaders from Russia's military, civilian defense establishment, and legislature attended the conference. The conference was sponsored jointly by the Council on Foreign and Defense Policy (Russia), the *Independent Military Review* (Russia), and CCMR (NPS). Russian newspapers covered the entire conference and published excerpts from recorded transcripts. The U.S. team was there to assist Russia in determining the feasibility of ending its military draft, and the conference became a significant event in U.S.-Russian relations and military cooperation relatively soon after the end of the long Cold War.

- In 1999, Eitelberg founded the NPS Center for Recruiting Innovation with significant funding from OSD and the Department of Navy (DoN). The Center's research and development activities supported the Navy's modernization of recruiting with an online presence and improved use of technology. "America's Army," the widely popular U.S. Army interactive game, is based on a concept developed originally for OSD and DoN by Dr. Eitelberg and his associates. Additionally, Dr. Eitelberg co-created the Navy's "Life Accelerator" (an interest inventory similar to DoD's "Interest Finder"), launched on Navy.com in March 2001. He updated the award-winning feature on his own in 2005. The very same interest inventory that Dr. Eitelberg produced in 2005 is still used today as the Navy "Life Ops Test" on Navy.com. It is estimated that well over 8 million young men and women, potential Navy recruiting prospects, have taken the "Life Accelerator" or "Life Ops Test" since it was first introduced in 2001.

- From 1998 through 2001, Dr. Eitelberg served as Editor-in-Chief of *Armed Forces & Society*, a highly respected, interdisciplinary scholarly journal with subscribers in over 55 countries. The primary editorial office was located at NPS during this time. Eitelberg supervised an editorial assistant, funded by NPS, three book review editors from the NPS faculty, 25 associate editors, and a copy editor who resided in Baltimore, Maryland. Each issue of the quarterly journal typically included six double-blind, peer-reviewed articles and ten book reviews. Eitelberg was invited to continue as editor for another term, but NPS declined to provide the required editorial support.

- From 1993 through 2014, Eitelberg directed an NPS study of the controversial DoD policy known as "Don't Ask, Don't Tell." A survey of NPS students was developed and first administered in 1994. Thereafter, for the next 20 years, the same survey was re-administered periodically and reported in seven NPS Master's theses. These surveys were sanctioned, yet unique, due to a longstanding DoD prohibition on surveys of active-duty personnel regarding the policy. The last administration of the survey occurred in 2013 to study changing attitudes after removal of the policy. The results are reported in two separate theses by teams of two students on each study. During the 20-year period, Eitelberg advised a number of other Master's theses related to the policy. He served on a University of California Blue Ribbon Commission to estimate the costs of the policy. He also wrote published reviews of two books on the policy, presented conference papers, assisted researchers at several universities, sponsored a speaker's program at NPS, and assisted the DoD Comprehensive Review Working Group, which developed a phased plan to remove the policy.

- In Dr. Eitelberg's 34+ years at NPS, he advised about 250 Master's theses and taught roughly 3,000 students in resident courses, amassing over 12,000 student-contact hours. He

created two popular resident courses, MN4114 Foundations of Military Sociology/Psychology and GB4044 Defense-Focused Managerial Inquiry. He created a LEAD Curriculum Course (distance learning at the U.S. Naval Academy), MN4113 Leadership Dimensions of Military Psychology/Sociology. He completely redesigned two other courses at NPS, GB3041 Analytical Tools for Managerial Decisions and MN4106 Military Manpower Policy Analysis, the capstone course in the Manpower Systems Analysis Curriculum. He served as Principal Investigator on many NPS research projects with considerable funding from external sponsors. From 1983-1990, he also served as Contracting Officer's Technical Representative (COTR) for NPS on research contracts worth several million dollars.

- Trivia: He was hired by NPS in 1982 as an Adjunct Research Associate Professor of Public Administration and the very first member of the newly formed Manpower Research Center. In 1986, the research center disbanded and transformed into the Department of Defense Personnel Security Research and Education Center (PERSEREC), still located in Monterey as part of the Office of Personnel Analytics under the Office of the Under Secretary of Defense (Personnel and Readiness). Eitelberg maintained joint offices in PERSEREC and in NPS for some years thereafter.

- Trivia: In August 2000, Dr. Eitelberg received the American Psychological Association's (Division 19/Society for Military Psychology) Robert M. Yerkes Military Psychology Award for outstanding contributions to military psychology by a non-psychologist. Yerkes is the "founding father" of military psychology. Other recipients of the annual award include General Maxwell Thurman, Senator Daniel Inouye, Senator Elizabeth Dole, and Senator Kay Bailey Hutchison.

- Trivia: He developed and supervised the first M-16 rifle training and qualification program for women reservists while serving with the 1st U.S. Women's Army Corps (WAC) Basic Training Battalion, 80th Division (Training), U.S. Army Reserve, Alexandria, Virginia.

- Trivia: He is a graduate of Columbia High School in Maplewood, New Jersey, where he was School President in his senior year. A large, regional public school (over 2,000 students) with a rich history, Columbia is well-known for its *many* notable alumni: https://en.wikipedia.org/wiki/Columbia_High_School_(New_Jersey)

- Trivia: As a junior in high school, he painted a large mural that was placed on permanent display in the New Jersey State Fire Museum.

Education

Ph.D.	1979	New York University (Public Administration: Public Policy and National Security)
M.P.A.	1973	New York University, Wagner School of Public Service (Public Administration Theory and Practice)
A.B.	1970	Franklin and Marshall College (Government and Religious Studies)

Professional Experience

Graduate School of Business and Public Policy
U.S. Naval Postgraduate School
Monterey, California

2017-Present	Emeritus Professor of the Naval Postgraduate School
1999-2017	Professor of Public Policy
1989-1999	Associate Professor of Public Administration and Associate Chair for Research (Tenured, 1995)
1982-1989	Adjunct Research Associate Professor of Public Administration

Major Activities:

- Associate Dean for Faculty Affairs. (2007-2008)
- Founding Director, Center for Recruiting Innovation. (1999-2004)
- Associate Chair (Research), Department of Systems Management, and Charter Member, Naval Postgraduate School Research Board. (1995-1999)
- Academic Associate (Program Director) for the Manpower, Personnel, and Training Analysis Curriculum. (1990-1993)
- Director of research projects for the Office of the Secretary of Defense, the Department of the Army, the Department of the Navy, and other government agencies. (1982-Present)
- Teaching professor (Introduction to Manpower, Personnel, and Training Analysis; Manpower/Personnel Policy Analysis; Manpower/Personnel Seminar; Selected Topics in Management Science; Foundations in Military Sociology and Military Psychology; Research Methods; Defense-Focused Managerial Inquiry). Recognized as among "Top Five Percent" in Award for Teaching Excellence, 1997. (1983-Present)
- Faculty Team Leader, Russia Seminar (Moscow), Center for Civil-Military Relations. (1997-1998)
- Faculty, Center for Civil-Military Relations. Lecturer in several seminar programs. (1997-2005)
- Faculty, Leadership Development and Education Program, United States Naval Academy and Naval Postgraduate School. (1997-1999)
- Thesis advisor in the Manpower Systems Analysis Curriculum. (Over 250 Master's theses, 1983-Present)

- Contracting Officer's Technical Representative (COTR) on research contracts totaling several million dollars. (1983-1990)

- Author; consultant in military manpower policy and national security; frequent contributor to national news media; manuscript reviewer for commercial publishers; and reviewer for academic journals in national security and military psychology.

Human Resources Research Organization
Alexandria, Virginia

1979-1982	Senior Scientist
1976-1979	Research Scientist
1975-1976	Research Associate
1975	Research Assistant

Major Activities:

- Research project director and principal investigator; author of numerous technical reports, papers, and government documents. Recipient of Professional Performance Merit Award, "HumRRO Researcher of the Year" (1982).

- Consultant to Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics). Recipient of Office of the Secretary of Defense Certificate of Appreciation for "valuable contributions to military manpower research" (1982).

- Deputy Director of Management Sciences Group. (1976-1979)

Other Positions (Selected)

- Visiting Research Collaborator, Office of Population Research, Woodrow Wilson School of Public and International Affairs, Princeton University. (Sabbatical, 2001-2002)

- U.S. Department of Defense representative on The Technical Cooperation Program (TTCP), an international, cooperative program in the defense sciences and technologies. Member of HUM-TP3 (formerly UTP-3), panel on "Military Human Resource Issues." (1990-2001)

- Editor-in-Chief, *Armed Forces & Society*, the official journal of the Inter-University Seminar on Armed Forces and Society (IUS). Founded in 1974 (the original Board of Editors included Morris Janowitz, Raymond Aron, Samuel E. Finer, and Jacques Van Doorn), *AF&S* now reaches scholars from many disciplines in over 50 countries. The editor supervises an editorial assistant, a managing editor, and three book review editors, and is assisted by 25 associate editors as well as numerous manuscript reviewers from around the world. (1998-2001)

- Member and Contributing Author, Committee on the Youth Population and Military Recruitment: Physical, Medical, and Mental Health Standards, National Research Council of the National Academies. (2004-2005)

- Member and Contributing Author, Committee on Techniques for the Enhancement of Human Performance, National Research Council, National Academy of Sciences. (1997-2000)

- Consultant, RAND Corporation. (1998-2000)

- Consultant, Campbell-Ewald, Warren, Michigan. (2000-2010)

- Consultant and Author, National Commission on Testing and Public Policy, University of California, Berkeley. (1988-1989)

- Consultant and Author, Global Demographic Trends Group, President's Commission on Integrated Long-Term Strategy, National Defense University, Washington, DC. (1987-1988)

- Consultant, Human Resources Research Organization (HumRRO). (1983-1986; 2005-2010)

- Associated Staff, Foreign Policy Studies Program, Brookings Institution, Washington, DC. (1980-1982)

- Member and Contributing Author, Military Service Working Group, The Atlantic Council of the United States, Washington, DC. (1980-1981)

- Personnel Analyst, State of New Jersey. (1975)

Board and Other Commission Memberships

- Board of Editors, *Armed Forces & Society*. (2001-Present)

- Board of Editors, *Military Psychology*. (2001-2005)

- Board of Directors, Toro Little League and Board of Directors, Toro Pony League (Toro Park, Corral de Tierra, and Salinas, California). (1997-2001)

- University of California Blue Ribbon Commission on Estimating the Costs of Excluding Homosexuals from the US Military. (2005-2006)

- Institutional Review Board, Naval Postgraduate School. (2004-2017)

Current Professional Affiliations and Selected Awards

Department of the Navy Superior Civilian Service Award, April 2017.

Elected Member (formerly, four terms) of Governing Council and Fellow, Inter-University Seminar on Armed Forces and Society, Chicago, Illinois. Founder and Chair of the Pacific Coast Chapter.

American Psychological Association, Division 19 (Society for Military Psychology), Washington, DC. Recipient of "Robert M. Yerkes Award" for outstanding contributions to military psychology by a non-psychologist, August 2000.

International Military Testing Association, Washington, DC.

Military Service

Honorable Discharge, United States Army (Reserve), 1976.

Staff Sergeant, Command Group, 1st U.S. Women's Army Corps Basic Training Battalion, 80th Division (Training), U.S. Army Reserve, Alexandria, Virginia. (1975-1976)

From Private to Staff Sergeant, Headquarters and Headquarters Troop, 5th Squadron, 117th Cavalry, 50th Armored Division, New Jersey Army National Guard, Westfield, New Jersey. (1970-1975)

Selected Publications and Presentations

Books

Sackett, Paul R., Eitelberg, Mark J., and Sellman, W.S. *Profiles of American Youth: Generational Changes in Cognitive Ability* (Under Review for Publication).

Committee on the Youth Population and Military Recruitment, National Research Council, *Assessing Fitness for Military Enlistment: Physical, Medical, and Mental Health Standards*. Washington, DC: The National Academies Press, 2006.

Committee on Techniques for the Enhancement of Human Performance, National Research Council, *The Changing Nature of Work: Implications for Occupational Analysis*. Washington, DC: National Academy Press, 1999.

Eitelberg, Mark J. and Mehay, Stephen L., eds. *Marching Toward the 21st Century: Military Manpower and Recruiting.* Westport, CT: Greenwood Press, 1994.

Eitelberg, Mark J., Laurence, Janice H., and Brown, Dianne C. *Becoming Brass.* (See same title under "Chapters in Books." Subject of cover story, "Brains on Board," *Navy Times*, 14 August 1989, pp. 14-16.)

Eitelberg, Mark J. *Manpower for Military Occupations*. Washington, DC: Office of the Assistant Secretary of Defense (Force Management and Personnel), April 1988. (Monograph Series)

Eitelberg, Mark J., Laurence, Janice H., and Waters, Brian K. (with Perelman, Linda S.). *Screening for Service*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics), September 1984. (Monograph Series)

Binkin, Martin and Eitelberg, Mark J. *Blacks and the Military*. Washington, DC: The Brookings Institution, 1982.

Doctoral Dissertation

Eitelberg, Mark J. *Military Representation: The Theoretical and Practical Implications of Population Representation in the American Armed Forces*. Doctoral Dissertation. New York University, October 1979. (Principal Advisor: Frank N. Trager.) Summarized in *Dissertation Abstracts International*, Volume 40, No. 11, May 1980, p. 6000-A. (Order No. 8010342.)

Chapters in Books

Eitelberg, Mark J. "Women and Minorities in the Military: Charting a Course for Research," in *Managing Diversity in the Military*. Edited by Mickey R. Dansby, James B. Stewart, and Schuyler C. Webb. New Brunswick, NJ: Transaction Publishers, 2001.

Eitelberg, Mark J. "The All-Volunteer Force after Twenty Years," in *Professionals on the Front Line: Two Decades of the All-Volunteer Force.* Edited by J. Eric Fredland, Curtis L. Gilroy, Roger D. Little, and W.S. Sellman. Washington, DC.: Brassey's, 1996.

Eitelberg, Mark J. and Little, Roger D. "Influential Elites and the American Military after the Cold War," in *US Civil-Military Relations: In Crisis or Transition?* Edited by Don M. Snider and Miranda A. Carlton-Carew. Washington, DC: The Center for Strategic and International Studies, 1995).

Eitelberg, Mark J. and Mehay, Stephen L. "The Shape of Things to Come," in *Marching Toward the 21st Century: Military Manpower and Recruiting.* Edited by Mark J. Eitelberg and Stephen L. Mehay. Westport, Connecticut: Greenwood Press, 1994.

Eitelberg, Mark J. and Mehay, Stephen L. "Demographics and the American Military at the End of the Twentieth Century," in *U.S. Domestic and National Security Agendas: Into the 21st Century*. Edited by Sam C. Sarkesian and John Flanagin. Westport, Connecticut: Greenwood Press, 1994.

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	

SUPPLEMENTAL DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.

2. I previously submitted a declaration in the above-captioned case describing my professional education, experience, and background, including my awareness of the extensive process that led to the adoption of a Department of Defense policy in June 2016 permitting transgender people to serve in the military.

THE CATEGORIZATION OF MEDICAL CONDITIONS RELATED TO GENDER IDENTITY IN THE ICD-10 AND THE FORTHCOMING ICD-11

3. The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), which is expected to be approved by the World Health Assembly in May 2018. *See* Exhibit A, Geoffrey M. Reed et al., "Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 based on current scientific evidence, best clinical practices, and human rights considerations," World Psychiatry 15:3, 205 (October 2016) [hereinafter Reed].

4. The ICD-10 was approved in 1990, nearly thirty years ago. The current period between revisions is the longest in the history of the ICD, which has resulted in some portions of the ICD-10 being significantly outdated. In particular, the portions of the ICD-10 relating to gender identity required significant revision in order to reflect advances in the research and the current scientific understanding of gender identity, transgender people, and the medical treatments for medical conditions relating to gender identity and gender dysphoria.

5. In order to provide scientifically and clinically sound recommendations about these needed revisions, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research appointed a Joint Working Group to develop specific recommendations for how to revise the ICD-10 categories relating to gender identity. The Joint Working Group reviewed available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 categories, in addition to other relevant materials, including what were then proposals for revising the American Psychiatric Association's DSM-5. The Joint Working Group made specific proposals regarding the placement and organization of categories and drafted diagnostic guidelines for the ICD-11 recommended diagnostic categories. I was invited to present my ideas on these matters at a meeting of this group in Oslo, Norway, and I had the opportunity to meet with Mr. Reed personally regarding the revisions.

6. The Joint Working Group recommended retaining diagnoses for gender incongruence (a new term that replaces Transsexualism and Gender Identity Disorder, but applies to the same patients previously diagnosed with these conditions) in order to preserve access to health service for transgender people, but moving these categories out of the ICD-11 chapter on Mental and Behavioral Disorders to the proposed new ICD-11 chapter on Conditions Related to Sexual

Health. The Working Group recommended changing the ICD-10 category F64.0 Transsexualism to Gender Incongruence of Adolescence and Adulthood and the ICD-10 F64.2 Gender Identity Disorder of Childhood to Gender Incongruence of Childhood.

7. The main reason for moving and renaming these diagnoses was to reflect current scientific research and knowledge about gender identity and transgender people, which recognizes that being transgender is not a disorder, that transition-related care is a basic aspect of promoting health and well-being for transgender people, and that gender dysphoria is a curable condition.

8. In light of these proposed revisions, it would be inappropriate and inaccurate to rely upon the outdated categorization of transsexualism and other medical conditions related to gender identity in the ICD-10 in any current discussion of these conditions. Further, in the ICD-10 terminology of 1990, it was never the case that clinicians working in this field of medicine considered transsexualism or gender identity disorder a "personality disorder" even though the Subgrouping, Gender Identity Disorders, was listed under the Grouping "Disorders of adult personality and behavior" in the Chapter entitled "Mental and Behavioral Disorders" in ICD-10. This erroneous placement for gender identity disorders will be corrected in ICD-11, where it is made clear that the replacement term, "gender incongruence," is not a personality or behavioral disorder. This important clarification is consistent with my professional opinion and those of the vast majority of researchers and clinicians who work with persons with gender incongruence/gender dysphoria (see Reed).

9. There is no medical or scientific basis for categorizing transsexualism, gender dysphoria or any other medical condition associated with transgender people as a personality or behavioral disorder.

WAIVERS

10. Because the new accessions policy articulated by Secretary Carter has not been put into effect, the pre-June 2016 military policy for transgender persons continues to govern the standards for accession/entry. That policy treats individuals with gender dysphoria differently than people with other curable conditions in a variety of ways, including that persons with clinically active gender dysphoria, or who have been treated for gender dysphoria in the past, are not able to obtain the same medical waivers that are available for most other medical conditions. For example, it is not uncommon for waivers to be granted for overweight individuals if the individual offers a critical skill for military readiness.

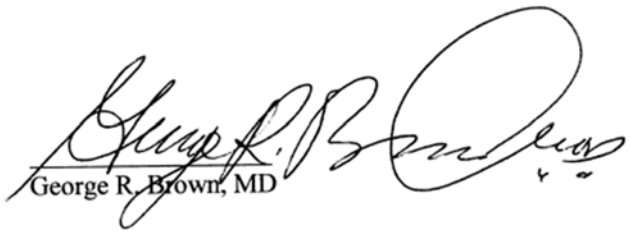
11. The enlistment policy allows for the possibility of waivers for a variety of medical conditions. However, entry waivers will not be granted for conditions that would disqualify an individual from the possibility of retention. Transgender people cannot obtain medical waivers to enter the military because being transgender is a disqualifying condition for retention.

12. The enlistment policy treats transgender individuals in an inconsistent manner compared with how the military addresses persons with other curable medical conditions. The result of this inconsistency is that transgender personnel are excluded or singled out for disqualification from enlistment, even when they are mentally and physically healthy.

13. In my 32 years of working as an active duty military psychiatrist or VHA psychiatrist, I am unaware of any waiver ever being granted for any transgender person seeking to enlist in any branch of the Armed Forces.

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

DATED: October 13, 2017



George R. Brown, MD

Exhibit A

SPECIAL ARTICLE

Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations

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In the World Health Organization's forthcoming eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), substantial changes have been proposed to the ICD-10 classification of mental and behavioural disorders related to sexuality and gender identity. These concern the following ICD-10 disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders associated with sexual development and orientation. Changes have been proposed based on advances in research and clinical practice, and major shifts in social attitudes and in relevant policies, laws, and human rights standards. This paper describes the main recommended changes, the rationale and evidence considered, and important differences from the DSM-5. An integrated classification of sexual dysfunctions has been proposed for a new chapter on Conditions Related to Sexual Health, overcoming the mind/body separation that is inherent in ICD-10. Gender identity disorders in ICD-10 have been reconceptualized as Gender incongruence, and also proposed to be moved to the new chapter on sexual health. The proposed classification of Paraphilic disorders distinguishes between conditions that are relevant to public health and clinical psychopathology and those that merely reflect private behaviour. ICD-10 categories related to sexual orientation have been recommended for deletion from the ICD-11.

Key words: International Classification of Diseases, ICD-11, sexual health, sexual dysfunctions, transgender, gender dysphoria, gender incongruence, paraphilic disorders, sexual orientation, DSM-5

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The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11). The ICD-11 is expected to be approved by the World Health Assembly in May 2018. The ICD-10 was approved in 1990, making the current period between revisions the longest in the history of the ICD.

In 2007, the WHO Department of Mental Health and Substance Abuse appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, to provide policy guidance and consultation throughout the development of the ICD-11 classification of mental and behavioural disorders[1]. As the revision process advanced, a series of Working Groups in different disorder content areas were also appointed to review available evidence and develop recommendations regarding needed revisions in specific diagnostic groupings[2].

From early in the revision process, it was clear that there were a series of complex and potentially controversial issues associated with the ICD-10 categories related to sexuality and gender identity, including the following disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders associated with sexual development and orientation. During the more than 25 years since the approval of ICD-10, there have been substantial advances in research relevant to these categories, as well as major changes in social attitudes and in relevant policies, laws, and human rights standards.

Due to the complexity of this context and the need to take a broad perspective in order to develop scientifically and clinically sound recommendations that would facilitate access to health services, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research have worked together to propose revisions in these areas. The two WHO departments appointed a joint Working Group on Sexual Disorders and Sexual Health to assist in the development of specific recommendations.

The first task of the Working Group was to review available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 diagnostic categories identified above. These issues were examined within various settings, including primary care and specialist health care settings, as well as social service and forensic contexts. Also considered were human rights issues pertinent to diagnostic classification in each of the areas under the Working Group's purview. The Working Group was also asked to review what were then proposals for the American

Psychiatric Association's DSM-5[3], and to consider the clinical utility of those proposals and their suitability for global implementation in various settings. Finally, the Working Group was asked to prepare specific proposals, including the placement and organization of categories, and to draft diagnostic guidelines for the ICD-11 recommended diagnostic categories, in line with the overall ICD revision requirements[2].

The following sections describe the main recommended changes for the above-mentioned four areas in the ICD-11 as compared to ICD-10. The ICD-10 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders[4], the version intended for use by specialist mental health professionals, is used as the frame of reference for this comparison. The rationale for changes, the evidence considered, and specific comments on differences from DSM-5 are also provided.

PROPOSED CHANGES TO F52 SEXUAL DYSFUNCTIONS, NOT CAUSED BY ORGANIC DISORDER OR DISEASE

The ICD-10 classification of Sexual dysfunctions (F52) is based on a Cartesian separation of "organic" and "non-organic" conditions. Sexual dysfunctions considered "non-organic" are classified in the ICD-10 chapter on Mental and Behavioural Disorders, and most "organic" sexual dysfunctions are classified in the chapter on Diseases of the Genitourinary System. However, substantial evidence has accumulated since ICD-10's publication indicating that the origin and maintenance of sexual dysfunctions frequently involves the interaction of physical and psychological factors[5]. The ICD-10 classification of sexual dysfunctions is therefore not consistent with current, more integrative clinical approaches in sexual health[6-9].

The Working Group on Sexual Disorders and Sexual Health has proposed an integrated classification of sexual dysfunctions for ICD-11 (see Table 1) that is more closely informed by current evidence and best practices, to be included in a new ICD-11 chapter on Conditions Related to Sexual Health[10]. The proposed integrated classification encompasses the sexual dysfunctions listed in the ICD-10 chapter on Mental and Behavioural Disorders and many of those currently found in the chapter on Diseases of the Genitourinary System[11].

In the proposed diagnostic guidelines for ICD-11, sexual response is described as a complex interaction of psychological, interpersonal, social, cultural, physiological and gender-influenced processes. Any of these factors may contribute to the development of sexual dysfunctions[8], which are described as syndromes that comprise the various ways in which people may have difficulty experiencing personally satisfying, non-coercive sexual activities.

The proposed ICD-11 diagnostic guidelines organize Sexual dysfunctions into four main groups: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. In addition, a separate grouping of Sexual pain disorders has been proposed. Where possible, categories in the proposed classification of sexual dysfunctions apply to both men and women, emphasizing commonalities in sexual response[12,13] (e.g., Hypoactive sexual desire dysfunction, Orgasmic dysfunction), without ignoring established sex differences in the nature of these experiences[14]. Men and women exhibit similar central nervous system pathways of activation and deactivation and similar neurotransmitter activity related to sexual desire. Dynamic alterations of sexual response are similarly modulated and reinforced by behaviour, experience and neuroplasticity. Separate sexual dysfunctions categories for men and women are provided where sex differences are related to distinct clinical presentations (e.g., Female sexual arousal dysfunction in women as compared to Erectile dysfunction in men).

The proposed guidelines indicate that, in order to be considered a sexual dysfunction, the problem or difficulty should generally: a) have been persistent or recurrent over a period of at least several months; b) occur frequently, although it may fluctuate in severity; and c) be associated with clinically significant distress. However, in cases where there is an immediate acute cause of the sexual dysfunction (e.g., a radical prostatectomy or injury to the spinal cord in the case of Erectile dysfunction; breast cancer and its treatment in Female sexual arousal dysfunction), it may be appropriate to assign the diagnosis even though the duration requirement has not been met, in order to initiate treatment.

The proposed diagnostic guidelines make clear that there is no normative standard for sexual activity. "Satisfactory" sexual functioning is defined as being satisfying to the individual, i.e. the person is able to participate in sexual activity and in a sexual relationship as desired. If the individual is satisfied with his/her pattern of sexual experience and activity, even if it is different from what may be satisfying to other people or what is considered normative in a given culture or subculture, a sexual dysfunction should not be diagnosed. Unrealistic expectations on the part of a partner, a discrepancy in sexual desire between partners, or inadequate sexual stimulation are not valid bases for a diagnosis of sexual dysfunction.

The proposed ICD-11 classification uses a system of harmonized qualifiers that may be applied across categories to identify the important clinical characteristics of the sexual dysfunctions. A *temporal qualifier* indicates whether the sexual dysfunction is *lifelong*, i.e. the person has always experienced the dysfunction from the time of initiation of relevant sexual activity, or *acquired*, i.e. the onset of the sexual dysfunction has followed a period of time during which the person did not experience it. A *situational qualifier* is used to indicate whether the dysfunction is *generalized*, i.e. the desired response is absent or diminished in all circumstances, including masturbation, or *situational*, i.e. the desired response is absent or diminished in some circumstances but not in others (e.g., with some partners or in response to some stimuli).

An innovative feature of the proposed ICD-11 classification of Sexual dysfunctions and Sexual pain disorders, and an

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments
***Chapter*:** Conditions Related to Sexual Health ***Grouping*:** Sexual dysfunctions	***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Behavioural syndromes associated with physiological disturbances and physical factors ***Subgrouping*:** Sexual dysfunction, not caused by organic disorder or disease ***Chapter*:** Diseases of the Genitourinary System ***Grouping*:** Diseases of male genital organs ***Subgrouping*:** Other disorders of penis ***Grouping*:** Noninflammatory disorders of female genital tract ***Subgrouping*:** Pain and other conditions associated with female genital organs and menstrual cycle	***Grouping*:** Sexual dysfunctions	• In ICD-11, Sexual dysfunctions have been included in a new chapter called Conditions Related to Sexual Health. • ICD-11 Sexual dysfunctions proposals represent an integrated classification, including conditions listed in Mental and Behavioural Disorders chapter in ICD-10 and many of those currently found in Diseases of the Genitourinary System. • In ICD-11, there are four main groupings of sexual dysfunctions: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. There is another separate grouping of Sexual pain disorders. • DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
***Category*:** Hypoactive sexual desire dysfunction	***Category*:** Lack or loss of sexual desire	***Category***: Female sexual interest/arousal disorder; Male hypoactive sexual desire disorder	• In ICD-11, Hypoactive sexual desire dysfunction can be applied to both men and women; In DSM-5, Female sexual interest/arousal disorder is separated from Male hypoactive sexual desire disorder.
Category*: Recommended for deletion*	***Category***: Sexual aversion	***Category***: Not included	• In ICD-11, the ICD-10 category Sexual aversion would be classified under Sexual pain-penetration disorder or under Specific phobia, depending on specific nature of symptoms. • In DSM-5, that category would similarly be classified as Genital-pelvic pain/penetration disorder or under Specific phobia.
Category: Female sexual arousal dysfunction	***Category***: Failure of genital response; Lack of sexual enjoyment	***Category***: Female sexual interest/arousal disorder	• In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • In ICD-11, the psychological component of arousal involved in ICD-10 Lack of sexual enjoyment is also subsumed in women under Female sexual arousal dysfunction.
Category: Erectile dysfunction	***Category***: Failure of genital response; Impotence of organic origin	***Category***: Erectile disorder	• In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • ICD-11 includes "organic" Erectile dysfunctions.
Category: Orgasmic dysfunction	***Category***: Orgasmic dysfunction	***Category***: Female orgasmic disorder	• In ICD-11, Orgasmic dysfunction can be applied to both men and women. • In ICD-11, there is a distinction between subjective experience of orgasm in men and ejaculation.

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5 *(continued)*

Proposed ICD-11	ICD-10	DSM-5	Comments
Category: Early ejaculation	***Category***: Premature ejaculation	***Category***: Premature (early) ejaculation	• Terminology in ICD-11 changed from Premature ejaculation to Early ejaculation.
Category: Delayed ejaculation	***Category***: Orgasmic dysfunction	***Category***: Delayed ejaculation	• DSM-5 does not distinguish between subjective experience of orgasm and ejaculation in men.
Category: Other specified sexual dysfunction	***Category***: Other sexual dysfunction, not caused by organic disorder or disease; Other specified disorders of penis; Other specified conditions associated with female genital organs and menstrual cycle	***Category***: Other specified sexual dysfunction	• DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
Category: Unspecified sexual dysfunction	***Category***: Unspecified sexual dysfunction, not caused by organic disorder or disease; Disorder of penis, unspecified; Unspecified condition associated with female genital organs and menstrual cycle	***Category***: Unspecified sexual dysfunction	• DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
Category: Sexual pain-penetration disorder (in separate grouping of Sexual pain disorders)	***Category***: Nonorganic vaginismus; Vaginismus (organic)	***Category***: Genito-pelvic pain/penetration disorder	• In ICD-11, Sexual pain penetration disorder includes Vaginismus and excludes Dyspareunia and Vulvodynia, which are classified in the Genitourinary chapter. • In DSM-5, Genito-pelvic pain/penetration disorder groups includes Dyspareunia and Vulvodynia if it occurs during penetration attempts or vaginal intercourse.

important one for a system that does not attempt to divide "organic" and "non-organic" dysfunctions, is a system of *etiological qualifiers* that may be applied to these categories. These qualifiers are not mutually exclusive, and as many may be applied as are considered to be relevant and contributory in a particular case. Proposed qualifiers include the following:

- *Associated with disorder or disease classified elsewhere, injury or surgical treatment* (e.g., diabetes mellitus, depressive disorders, hypothyroidism, multiple sclerosis, female genital mutilation, radical prostatectomy)[15-19];
- *Associated with a medication or substance* (e.g., selective serotonin reuptake inhibitors, histamine-2 receptor antagonists, alcohol, opiates, amphetamines)[20,21];
- *Associated with lack of knowledge* (e.g., about the individual's own body, sexual functioning, and sexual response)[22];
- *Associated with psychological or behavioural factors* (e.g., negative attitudes toward sexual activity, adverse past sexual experiences, poor sleep hygiene, overwork)[23,24];
- *Associated with relationship factors* (e.g., relationship conflict, lack of romantic attachment)[25,26];
- *Associated with cultural factors* (e.g., culturally-based inhibitions about the expression of sexual pleasure, the belief that loss of semen can lead to weakness, disease or death)[27,28].

Other changes that have been proposed include the elimination of the ICD-10 category F52.7 Excessive sexual drive from the classification of Sexual dysfunctions. The ICD-10 category F52.0 Loss or lack of sexual desire is more specifically categorized in ICD-11 as Hypoactive sexual desire dysfunction in women and men, Female sexual arousal dysfunction in women, or Erectile dysfunction in men. The ICD-10 category F52.10 Sexual aversion is classified in ICD-11 under Sexual pain-penetration disorder or under the grouping of Anxiety and fear-related disorders if it is used to describe a phobic response. The ICD-10 category F52.11 Lack of sexual enjoyment, which the ICD-10 indicates is more common in women, is captured primarily in the ICD-11 under Female sexual arousal dysfunction. Other possible reasons for lack of sexual enjoyment, including hypohedonic orgasm and painful orgasm[29], would be classified under Other specified sexual dysfunctions. The ICD-10 category F52.2 Failure of genital response is separated into two categories: Female sexual arousal dysfunction in women, and Erectile dysfunction in men.

Comparison with DSM-5

The proposed classification of sexual dysfunctions in ICD-11 is different from the DSM-5 in its attempt to integrate

dysfunctions that may have a range of etiological or contributory dimensions. The DSM-5 acknowledges that an array of factors may be relevant to etiology and treatment and may contribute to sexual dysfunctions; these include partner, relationship, individual vulnerability, cultural, religious, and medical factors. At the same time, the DSM-5 indicates that, if a sexual dysfunction is caused by a nonsexual medical disorder, the effects of a substance or medication, or a medical condition, a diagnosis of Sexual dysfunction would not be assigned. This is logical given the DSM-5's purpose as a classification of mental and behavioural disorders (even though it differs from the approach that DSM-5 has taken to Sleep-wake disorders and Neurocognitive disorders). Because ICD-11 is a classification of all health conditions, it provides the possibility for greater integration. The proposed ICD-11 classification allows for assigning a Sexual dysfunction diagnosis in situations in which this is an independent focus of treatment, regardless of presumed etiology. The presence of a variety of contributory factors may be recorded using the etiological qualifiers.

The DSM-5 has combined dysfunctions of sexual desire and sexual arousal in women in the category Female sexual interest/arousal disorder[30], which has proved to be quite controversial[31-35]. In contrast, the proposed ICD-11 category Hypoactive sexual desire dysfunction can be applied to both men and women, while Female sexual arousal dysfunction is classified separately. The separation of desire and arousal in women into distinct dysfunctions is supported by several lines of evidence, including genetic evidence from twin studies[36], studies of specific single nucleotide polymorphisms and the use of serotonergic antidepressant medications[37,38], and neuroimaging studies[39]. There is also evidence that Hypoactive desire disorder in women and men respond to similar treatments[40], and that these are different from treatments that are effective for Female sexual arousal disorder[41-43]. Although there is significant comorbidity between desire and arousal dysfunction, the overlap of these conditions does not mean that they are one and the same; research suggests that management should be targeted toward their distinct features[44].

The proposed classification of sexual pain in ICD-11 provides the possibility of identifying specific types of pain syndromes without excluding those in which another medical condition is considered to be contributory. The DSM-5 category Genito-pelvic pain/penetration disorder includes vaginismus, dyspareunia and vulvodynia not completely attributable to other medical conditions. A similar category of Sexual pain-penetration disorder has been proposed for ICD-11, but it does not include dyspareunia and vulvodynia, which have been retained as separate categories in the ICD-11 genitourinary chapter. These syndromes are characterized by different etiologies, occur in different populations, and have distinct treatment approaches[45-47].

Finally, the DSM-IV-TR category Male orgasmic disorder has been replaced in DSM-5 by Delayed ejaculation. This decision seems to have been largely based on a Medline search that indicated infrequent usage of terminology including orgasm as opposed to terminology specifying ejaculation for male disorders[48]. Another rationale for DSM-5 to modify the term was the small number of cases of male orgasmic disorder seen in clinical practice[49]. However, this was not only a modification of terminology but rather the lumping of two separate phenomena into a single category. The proposed ICD-11 classification of Sexual dysfunctions emphasizes the subjective experience of orgasm and separates it from the ejaculatory phenomenon, consistent with available research[50].

PROPOSED CHANGES TO F64 GENDER IDENTITY DISORDERS

Over the past several years, a range of civil society organizations as well as the governments of several Member States and the European Union Parliament have urged the WHO to remove categories related to transgender identity from its classification of mental disorders in the ICD-11[51-53].

One impetus for this advocacy has been an objection to the stigmatization that accompanies the designation of any condition as a mental disorder in many cultures and countries. The WHO Department of Mental Health and Substance Abuse is committed to a variety of efforts to reduce the stigmatization of mental disorders[54]. However, the stigmatization of mental disorders *per se* would not be considered a sufficient reason to eliminate or move a mental disorder category. The conditions listed in the ICD Mental and Behavioural Disorders chapter are intended to assist in the identification of people who need mental health services and in the selection of appropriate treatments[1], in fulfillment of WHO's public health objectives.

Nevertheless, there is substantial evidence that the current nexus of stigmatization of transgender people and of mental disorders has contributed to a doubly burdensome situation for this population, which raises legitimate questions about the extent to which the conceptualization of transgender identity as a mental disorder supports WHO's constitutional objective of "the attainment by all peoples of the highest possible level of health"[55]. Stigma associated with the intersection of transgender status and mental disorders appears to have contributed to precarious legal status, human rights violations, and barriers to appropriate health care in this population[56-58].

The WHO's 2015 report on *Sexual health, human rights, and the law*[58] indicates that, in spite of recent progress, there are still very few non-discriminatory, appropriate health services available and accessible to transgender people. Health professionals often do not have the necessary competence to provide services to this population, due to a lack of appropriate professional training and relevant health system standards[59-61]. Limited access to accurate information and appropriate health services can contribute to a variety of negative behavioural and mental health outcomes among transgender people, including increased HIV-related risk behaviour, anxiety, depression, substance abuse, and suicide[62-65]. Additionally,

Table 2 Classification of conditions related to gender identity in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[71,72]
Chapter: Conditions Related to Sexual Health ***Grouping***: Gender incongruence	***Chapter***: Mental and Behavioural Disorders ***Grouping***: Disorders of adult personality and behaviour ***Subgrouping***: Gender identity disorders	***Grouping***: Gender dysphoria	• ICD-11 does not classify Gender incongruence as a mental and behavioural disorder; Gender dysphoria is listed as a mental disorder in DSM-5. • ICD-11's primary focus is experience of incongruence between experienced gender and assigned sex; DSM-5 emphasizes distress related to gender identity through name of category and criteria.
Category: Gender incongruence of adolescence and adulthood	***Category***: Transsexualism	***Category***: Gender dysphoria in adolescents and adults	• ICD-11 contains four broad essential features and two are required for diagnosis; DSM-5 contains six criteria and two are required for diagnosis. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of several months; DSM-5 requires six months.
Recommended for deletion	***Category***: Dual-role transvestism	*Not included*	• Recommended for deletion from ICD-11 due to lack of public health or clinical relevance (not in DSM-5).
Category: Gender incongruence of childhood	***Category***: Gender identity disorder of childhood	***Category***: Gender dysphoria in children	• ICD-11 contains three essential features, all of which are required for diagnosis; DSM-5 contains eight diagnostic criteria, six of which must be present. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of two years, suggesting that the diagnosis cannot be made before approximately age 5; DSM-5 requires six months and does not set a lower age limit.
Recommended for deletion	***Category***: Other gender identity disorders	***Category***: Other specified gender dysphoria	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.
Recommended for deletion	***Category***: Gender identity disorder, unspecified	***Category***: Unspecified gender dysphoria	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.

many transgender people self-administer hormones of dubious quality obtained through illicit markets or online without medical supervision[66,67], with potentially serious health consequences[68-70]. For example, in a recent study of 250 transgender people in Mexico City, nearly three-quarters of participants had used hormones, and nearly half of these had begun using them without medical supervision[71].

In spite of WHO's concerted advocacy for mental health parity[54], a primary mental disorder diagnosis can exacerbate problems for transgender people in accessing health services, particularly those that are not considered to be mental health services. Even in countries that recognize the need for transgender-related health services and where professionals with relevant expertise are relatively available, private and public insurers often specifically exclude coverage for these services[58]. Classification as a mental disorder has also contributed to the perception that transgender people must be treated by psychiatric specialists, further restricting access to services that could reasonably be provided at other levels of care.

In most countries, the provision of health services requires the diagnosis of a health condition that is specifically related to those services. If no diagnosis were available to identify transgender people who were seeking related health services, these services would likely become even less available than they are now[72,73]. Thus, the Working Group on Sexual Disorders and Sexual Health has recommended retaining gender incongruence diagnoses in the ICD-11 to preserve access to health services, but moving these categories out of the ICD-11 chapter on Mental and Behavioural Disorders (see Table 2). After consideration of a variety of placement options[72], these

categories have been provisionally included in the proposed new ICD-11 chapter on Conditions Related to Sexual Health.

The Working Group has recommended reconceptualizing the ICD-10 category F64.0 Transsexualism as Gender incongruence of adolescence and adulthood[72] and the ICD-10 category F64.2 Gender identity disorder of childhood as Gender incongruence of childhood[73]. The proposed diagnostic requirements for Gender incongruence of adolescence and adulthood include the continuous presence for at least several months of at least two of the following features: a) a strong dislike or discomfort with primary or secondary sex characteristics due to their incongruity with the experienced gender; b) a strong desire to be rid of some or all of one's primary or secondary sex characteristics (or, in adolescence, anticipated secondary sex characteristics); c) a strong desire to have the primary or secondary characteristics of the experienced gender; and d) a strong desire to be treated (to live and be accepted as) a person of the experienced gender. As in the ICD-10, the diagnosis of Gender incongruence of adolescence and adulthood cannot be assigned before the onset of puberty. The duration requirement is reduced from two years in ICD-10 to several months in ICD-11.

The ICD-11 abandons ICD-10 terms such as "opposite sex" and "anatomic sex" in defining the condition, using more contemporary and less binary terms such as "experienced gender" and "assigned sex". Unlike ICD-10, the proposed ICD-11 diagnostic guidelines do not implicitly presume that all individuals seek or desire full transition services to the "opposite" gender. The proposed guidelines also explicitly pay attention to the anticipated development of secondary sex characteristics in young adolescents who have not yet reached the last physical stages of puberty, an issue that is not addressed in ICD-10.

The proposed ICD-11 diagnostic requirements for Gender incongruence of childhood are considerably stricter than those of ICD-10, in order to avoid as much as possible the diagnosis of children who are merely gender variant. All three of the following essential features must be present: a) a strong desire to be, or an insistence that the child is, of a different gender; b) a strong dislike of the child's own sexual anatomy or anticipated secondary sex characteristics, or a strong desire to have the sexual anatomy or anticipated secondary sex characteristics of the desired gender; and c) make believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The third essential feature is not meaningful without the other two being present; in their absence it is merely a description of gender variant behaviour. These characteristics must have been present for at least two years in a prepubertal child, effectively meaning that the diagnosis cannot be assigned prior to the age of approximately 5 years. The ICD-10 does not mention a specific duration requirement or a minimum age at which it is appropriate to assign the diagnosis.

The proposed diagnostic guidelines for both Gender incongruence of adolescence and adulthood and Gender incongruence of childhood indicate explicitly that gender variant behaviour and preferences alone are not sufficient for making a diagnosis; some form of experienced anatomic incongruence is also necessary. Importantly, the diagnostic guidelines for both categories indicate that gender incongruence may be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, particularly in disapproving social environments and where protective laws and policies are absent, but that neither distress nor functional impairment is a diagnostic requirement.

The area of transgender health is characterized by calls for change in health system responses[58,74,75], by rapid change in social attitudes in some countries, and by controversy. As a part of this work, the Working Group on Sexual Disorders and Sexual Health received proposals and opinions from a wide range of civil societies, professional organizations, and other interested parties[72,73]. The most controversial issue has been the question of whether the childhood diagnostic category should be retained[73]. The main argument advanced against retaining the category is that stigmatization associated with being diagnosed with *any* health condition – not just a mental disorder diagnosis – is potentially harmful to children who will in any case not be receiving medical interventions before puberty[76]. A more substantive critique is that, if it is the case that the problems of extremely gender-variant children arise primarily from hostile social reactions and victimization, assigning a diagnosis to the child amounts to blaming the victim[77]. This latter concern suggests a need for further research as well as a broader social conversation. The Working Group has recommended retaining the category based on the rationale that it will preserve access to treatment for this vulnerable and already stigmatized group. Treatment most often consists of specialized supportive mental health services as well as family and social (e.g., school) interventions[73], while treatments aimed at suppressing gender-variant behaviours in children are increasingly viewed as unethical.

The diagnosis also serves to alert health professionals that a transgender identity in childhood often does not develop seamlessly into an adult transgender identity. Available research instead indicates that the majority of children diagnosed with DSM-IV Gender identity disorder of childhood, which was not as strict in its requirements as those proposed for ICD-11, grow up to be cisgender (non-transgender) adults with a homosexual orientation[78-80]. In spite of the claims of some clinicians to be able to distinguish between children whose transgender identity is likely to persist into adolescence and adulthood and those likely to be gay or lesbian, there is considerable overlap between these groups in all predictors examined[80], and no valid method of making a prediction at an individual level has been published in the scientific literature. Therefore, while medical interventions are not currently recommended for prepubertal gender incongruent children, psychosocial interventions need to be undertaken with caution and based on considerable expertise so as not to limit later choices[59,81,82]. The inclusion of the category in the ICD-11 is intended to provide better opportunities for much-needed education of health professionals, the development of stand-

ards and pathways of care to help guide clinicians and family members, including adequate informed consent procedures, and future research efforts.

Finally, the ICD-10 category F64.1 Dual-role transvestism – occasionally dressing in clothing typical of another gender in order to "enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change"[4] or accompanying sexual arousal – has been recommended for deletion from the ICD-11, due to its lack of public health or clinical relevance.

Comparison with DSM-5

The most important difference between the proposals for ICD-11 and the DSM-5 is that the latter has retained the categories related to gender identity as a part of its classification of mental disorders. Both childhood and adult forms of Gender identity disorder in DSM-IV have been renamed in DSM-5 as Gender dysphoria, defined by "marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months' duration" and "clinically significant distress or impairment in social, school, or other important areas of functioning"[3]. Both the name of the DSM-5 condition – dysphoria – and the diagnostic criteria, therefore, emphasize distress and dysfunction as integral aspects of the condition. They are also the central rationale for classifying these conditions as mental disorders; without distress or dysfunction, gender dysphoria would not fulfill the requirements of DSM-5's own definition of a mental disorder.

In contrast, the proposal for ICD-11 is to include child and adult Gender incongruence categories in another chapter that explicitly integrates medical and psychological perspectives, Conditions Related to Sexual Health. The proposed ICD-11 diagnostic guidelines indicate that distress and dysfunction, although not necessary for a diagnosis of Gender incongruence, may occur in disapproving social environments and that individuals with gender incongruence are at increased risk for psychological distress, psychiatric symptoms, social isolation, school drop-out, loss of employment, homelessness, disrupted interpersonal relationships, physical injuries, social rejection, stigmatization, victimization, and violence. At the same time, particularly in countries with progressive laws and policies, young transgender people living in supportive environments still seek health services, even in the absence of distress or impairment. The ICD-11 approach provides for this.

A challenge to DSM-5 conceptualization of Gender dysphoria is, therefore, the question of whether distress and dysfunction related to the social consequences of gender variance (e.g., stigmatization, violence) can be distinguished from distress related to transgender identity itself[83,84]. A recent study of 250 transgender adults receiving services at the only publicly funded clinic in Mexico City providing comprehensive services for transgender people[71] found that distress and dysfunction associated with emerging transgender identity were very common, but not universal. However, more than three-quarters of participants reported having experienced social rejection and nearly two-thirds had experienced violence related to their gender identity during childhood or adolescence. Distress and dysfunction were more strongly predicted by experiences of social rejection and violence than by features related to gender incongruence. These data provide further support for ICD-11's conceptualization and the removal of gender incongruence from the classification of mental disorders.

Finally, there are several technical differences between the proposals for ICD-11 and DSM-5 in relation to these categories. The most substantive is that the DSM-5 diagnosis of Gender dysphoria of childhood requires a duration of only six months, in contrast to two years in the ICD-11 proposal, and does not specify a lower age limit at which the diagnosis can be applied.

PROPOSED CHANGES TO F65 DISORDERS OF SEXUAL PREFERENCE

From WHO's perspective, there is an important distinction between conditions that are relevant to public health and indicate the need for health services versus those that are simply descriptions of private behaviour without appreciable public health impact and for which treatment is neither indicated nor sought. This distinction is based on the ICD's central function as a global public health tool that provides the framework for international public health surveillance and health reporting. It is also related to the increasing use of the ICD over the past several decades by WHO Member States to structure clinical care and define eligibility for subsidized health services[1]. The regulation of private behaviour without health consequences to the individual or to others may be considered in different societies to be a matter for criminal law, religious proscription, or public morality, but is not a legitimate focus of public health or of health classification.

This requirement is particularly pertinent to the classification of atypical sexual preferences commonly referred to as paraphilias. The Working Group on Sexual Disorders and Sexual Health noted that the diagnostic guidelines provided for ICD-10's classification of Disorders of sexual preference often merely describe the sexual behaviour involved. For example, the ICD-10 diagnostic guidelines define F65.1 Fetishistic transvestism as "the wearing of clothes of the opposite sex principally to obtain sexual excitement"[4], without requiring any sort of distress or dysfunction and without reference to the public health or clinical relevance of this behaviour. This is at odds with ICD-10's general guidance for what constitutes a mental disorder and contradicts ICD-10's own statement that "social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder"[4]. According to this principle, specific patterns of sexual arousal that are merely relatively unusual[85,86], but are not associated with distress,

dysfunction or harm to the individual or to others[87,88], are not mental disorders. Labeling them as such does not contribute meaningfully to public health surveillance or to the design of health services, and may create harm to individuals so labeled[89]. Thus, a major consideration for the recommended revisions for ICD-11 in this area was whether an atypical sexual arousal pattern represented a condition of public health significance and clinical importance.

The Working Group recommended that Disorders of sexual preference be renamed as Paraphilic disorders to reflect the terminology used in the current scientific literature and in clinical practice[90]. The Group proposed that the paraphilic disorders included in ICD-11 consist primarily of patterns of atypical sexual arousal that focus on non-consenting others, as these conditions could be considered to have public health implications (see Table 3). The core proposed diagnostic requirements for a Paraphilic disorder in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal – as manifested by persistent sexual thoughts, fantasies, urges, or behaviours – that involves others whose age or status renders them unwilling or unable to consent (e.g., pre-pubertal children, an unsuspecting individual being viewed through a window, an animal); and b) that the individual has acted on these thoughts, fantasies or urges or is markedly distressed by them. There is no requirement in the proposed ICD-11 diagnostic guidelines that the relevant arousal pattern be exclusive or preferential.

This conceptualization has resulted in the recommendation to retain three ICD-10 categories in this section, each labeled specifically as a disorder rather than simply naming or describing the behaviour involved. These include Exhibitionistic disorder, Voyeuristic disorder, and Pedophilic disorder. In addition, two new named categories have been proposed: Coercive sexual sadism disorder and Frotteuristic disorder.

Coercive sexual sadism disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. This arousal pattern has been found to be prevalent among sex offenders treated in forensic institutions[92-96] and among individuals who have committed sexually motivated homicides[97]. The new proposed nomenclature of Coercive sexual sadism disorder was selected to clearly distinguish this disorder from consensual sadomasochistic behaviours that do not involve substantial harm or risk.

Frotteuristic disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person in public places. Frotteurism has been found to be among the most common of paraphilic disorders[98-102] and is a significant problem in some countries[103]. It was also included in DSM-IV and has been retained in DSM-5.

In addition, the category Other paraphilic disorder involving non-consenting individuals is proposed for use when the other diagnostic requirements for a paraphilic disorder are met but the specific pattern of sexual arousal does not fit into any of the available named categories and is not sufficiently common or well researched to be included as a named category (e.g., arousal patterns involving corpses or animals).

Based on the concerns described above, the Working Group proposed that three named ICD-10 categories – F65.0 Fetishism, F65.1 Fetishistic transvestism, and F65.5 Sadomasochism – be removed from the classification. Indeed, several countries (Denmark, Sweden, Norway and Finland) have already removed these categories from their national lists of accepted ICD-10 diagnoses, in response to similar concerns[104]. Instead, the proposed additional category Other paraphilic disorder involving solitary behaviour or consenting individuals may be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death (e.g., asphyxophilia, or achieving sexual arousal by restriction of breathing).

One additional requirement in the proposed diagnostic guidelines is that, when a diagnosis of Other paraphilic disorder involving solitary behaviour or consenting individuals is assigned based on distress, the distress should not be entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society). In these cases, codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services may be considered. These are non-disease categories that indicate reasons for clinical encounters and include Counselling related to sexual knowledge and sexual attitude, Counselling related to sexual behaviour and sexual relationships of the patient, and Counselling related to sexual behaviour and sexual relationship of the couple. These categories recognize the need for health services, including mental health services, that may be legitimately provided in the absence of diagnosable mental disorders[11].

The proposed diagnostic guidelines make clear that the mere occurrence or a history of specific sexual behaviours is insufficient to establish a diagnosis of a Paraphilic disorder. Rather, these sexual behaviours must reflect a sustained, focused, and intense pattern of paraphilic sexual arousal. When this is not the case, other causes of the sexual behaviour need to be considered. For example, many sexual crimes involving non-consenting individuals reflect actions or behaviours that may be transient or occur impulsively or opportunistically rather than reflecting either a persistent pattern of sexual arousal or any underlying mental disorder. However, sexual behaviours involving non-consenting individuals may also occur in the context of some mental and behavioural disorders, such as manic episodes or dementia, or in the context of substance intoxication. These do not satisfy the definitional requirements of a Paraphilic disorder.

The Working Group on Sexual Disorders and Sexual Health has also recommended that the proposed ICD-11 grouping of Paraphilic disorders be retained within the chapter on Mental and Behavioural Disorders rather than being moved to the proposed new chapter on Conditions Related to Sexual Health, for two main reasons. First, the assessment and treatment of Paraphilic disorders, which often takes place in forensic con-

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[90]
***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Paraphilic disorders	***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Disorders of adult personality and behaviour ***Subgrouping*:** Disorders of sexual preference	***Grouping*:** Paraphilic disorders	• ICD-11 name changed to be consistent with current scientific literature and clinical practice; brings it in line with DSM-5. • ICD-11 distinguishes between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. • Requirements for named Paraphilic disorders in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal that involves others whose age or status renders them unwilling or unable to consent; and b) that the individual has acted on the arousal patterns or is markedly distressed by it.
***Category*:** Exhibitionistic disorder	***Category*:** Exhibitionism	***Category***: Exhibitionistic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Voyeuristic disorder	***Category***: Voyeurism	***Category***: Voyeuristic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Pedophilic disorder	***Category***: Paedophilic disorder	***Category***: Pedophilic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders. • In DSM-5, diagnosis may be assigned based on the presence of "interpersonal difficulty" due to the arousal pattern, in the absence of action, distress, or functional impairment. • DSM-5 includes a variety of specifiers, which have been criticized for lack of consistency and questionable validity[91].
Category: Coercive sexual sadism disorder	*Not included*	*Not included*	• Defined by sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. • Not equivalent to DSM-5 Sexual sadism disorder or ICD-10 Sadomasochism, which do not distinguish between arousal patterns involving consenting and non-consenting others.
Category: Frotteuristic disorder	*Not included*	***Category***: Frotteuristic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Recommended for deletion	***Category***: Sadomasochism	***Category***: Sexual masochism disorder	• If consensual behaviour is involved, may be classified as in ICD-11 as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death. • If arousal pattern focuses on the infliction of suffering on non-consenting individuals, may be classified in ICD-11 as Coercive sexual sadism disorder.
Not included	*Combined with Sexual masochism*	***Category***: Sexual sadism disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5 *(continued)*

Proposed ICD-11	ICD-10	DSM-5	Comments[90]
Recommended for deletion	***Category***: Fetishism	***Category***: Fetishistic disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
Recommended for deletion	***Category***: Fetishistic transvestism	***Category***: Transvestic disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
Recommended for deletion	***Category***: Multiple disorders of sexual preference	*Not included*	• This ICD-10 category was not considered to be clinically informative. Multiple paraphilic disorder diagnoses may be assigned in both ICD-11 and DSM-5.
Category: Other paraphilic disorder involving non-consenting individuals	*Not included*	*Not included*	• May be used when the diagnostic requirements for a Paraphilic disorder are met but the specific pattern of sexual arousal does not fit into available named categories (e.g., arousal patterns involving corpses or animals).
Category: Other paraphilic disorder involving solitary behaviour or consenting individuals	*Not included*	*Not included*	• May be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death.
Recommended for deletion	***Category***: Other disorders of sexual preference	***Category***: Other specified paraphilic disorder	• Replaced in ICD-11 by above two "Other paraphilic disorder" categories, which specify whether arousal pattern involves: a) non-consenting individuals; or b) consenting individuals or solitary behaviour.
Recommended for deletion	***Category***: Disorder of sexual preference, unspecified	***Category***: Unspecified paraphilic disorder	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only relatively unusual patterns of sexual arousal that are not associated with distress, dysfunction, or harm to the individual or to others.

texts, requires specialized mental health expertise. Evidence-based treatments for Paraphilic disorders are almost entirely psychological and psychiatric in nature and require substantial mental health expertise to administer. When adjunctive somatic treatments are used (e.g., anti-androgen drugs), they are controversial and legally and clinically complex and must be administered within a psychiatric framework.

Second, a substantial portion of the assessment and treatment of Paraphilic disorders relates to the civil commitment, mitigation, and treatment of specific classes of sex offenders. This is a complex and controversial legal area that must be considered in defining how Paraphilic disorders should be classified. In many countries – including the US, Germany, the UK, Canada, and other countries whose legal systems are based on the British or German systems – there are laws that allow for the civil commitment and preventive detention of certain sexual offenders who are sometimes termed sexually violent predators. These laws permit involuntary commitment of such individuals to psychiatric facilities after they have completed mandatory prison sentences, to allow for continued treatment and minimization of risk to the community where these offenders are to be released.

In countries where the constitutionality of such laws has been challenged, they have been upheld[105]. However, crucial to the finding of constitutionality has been the determination by relevant courts that a risk of dangerousness by itself is not sufficient grounds for civil commitment under such statutes. Rather, the constitutional requirement specifically rests on a finding of the presence of a mental disorder as the basis for civil commitment because it "narrows the class of persons eligible for confinement to those who are unable to control their dangerousness"[106].

Although there are continuing controversies about the application of these laws in many countries[107,108], the Working Group on Sexual Disorders and Sexual Health did not consider that moving Paraphilic disorders out of the Mental and Behavioural Disorders chapter would be an appropriate or helpful way to address these concerns.

Comparison with DSM-5

The changes proposed for Paraphilic disorders in ICD-11 represent a major departure from ICD-10, which was developed during the late 1980s. In many ways, these changes align the ICD-11 more closely with the DSM-5. At the same time, there are substantive differences between the two systems. Sexual masochism disorder, Fetishistic disorder, and Transvestic disorder are included as named mental disorders in DSM-

5, while in ICD-11 these phenomena can be diagnosed under Other paraphilic disorder involving solitary behaviour or consenting individuals only if they are associated with significant distress or significant risk of injury or death.

The duration requirement proposed for Paraphilic disorders in ICD-11 is more flexible than the six-month requirement in DSM-5, which does not appear to have specific empirical support[109]. The ICD-11 guidelines require a clinical judgment that the arousal pattern is sustained, focused, and intense, making clear that a single instance of behaviour or criminal act does not meet this requirement. Functional impairment is included relatively automatically in diagnostic criteria for DSM-5, but has not been included as a part of the proposed ICD-11 diagnostic guidelines for Paraphilic disorders, in keeping with the general principle for ICD-11 Mental and Behavioural Disorders that impairment should only be used when necessary to distinguish a disorder from normality[1].

PROPOSED CHANGES TO F66 PSYCHOLOGICAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH SEXUAL DEVELOPMENT AND ORIENTATION

The ICD-10 explicitly states that "sexual orientation by itself is not to be considered a disorder"[4]. Nevertheless, the ICD-10 grouping of Psychological and behavioural disorders associated with sexual development and orientation suggests that there do exist mental disorders uniquely linked to sexual orientation. These categories include F66.0 Sexual maturation disorder, F66.1 Egodystonic sexual orientation, and F66.2 Sexual relationship disorder (see Table 4).

The Working Group on Sexual Disorders and Sexual Health emphasized that, although the ICD-10 F66 categories mention gender identity in their definitions, historically they emerged from concerns related to sexual orientation[89]. Over the last half century, international classification systems of mental disorders, including the ICD and the DSM, but also various national and regional classifications, have gradually removed diagnostic categories that defined homosexuality *per se* as a mental disorder. This reflects emerging human rights standards[56,110], the recognition that homosexual behaviour is a widely prevalent aspect of human behaviour[111], and the lack of empirical evidence to support pathologization and medicalization of variations in sexual orientation expression[112,113].

As noted earlier, the ICD-10 also indicates that "social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder"[4]. The Working Group viewed this exclusion as essential to the consideration of diagnostic categories linked to sexual orientation[89]. Given that expression of same-sex orientation continues to be heavily stigmatized in parts of the world[56,110], psychological and behavioural symptoms seen in non-heterosexual individuals may be products of persistently hostile social responses rather than expressions of inherent psychopathology. This perspective is supported by robust empirical evidence from international studies[114-116]. Violence, stigma, exclusion and discrimination linked to same-sex orientations is a worldwide phenomenon and has been documented as especially vicious, often showing a high degree of brutality[117]. In some countries, criminal law is still applied to consensual same-sex sexual activity, though international, regional and national human rights bodies have explicitly called for States to end this practice[56]. Thus, the Working Group concluded that, if a disease label is to be attached to a social condition, it is essential that the condition have demonstrable public health and clinical utility, for example by identifying a legitimate mental health need.

The core diagnostic features of F66.0 Sexual maturation disorder in the ICD-10 are: a) uncertainty about one's gender identity or sexual orientation and b) distress *about the uncertainty* rather than about the particular gender identity or sexual orientation. Research has repeatedly demonstrated that same-sex sexual orientation emerges over time[118], with the process typically beginning in late childhood or early adolescence. Often there is a substantial level of anti-gay stigma in the individual's social environment that creates stress for the individual. As distress arising from stigma cannot be considered as indicative of a mental disorder under the ICD-10 social conflict exclusion, the Working Group considered that this category conflates normative developmental patterns observed in gay, lesbian, bisexual, and transgender people with psychopathological processes.

The concept of egodystonic homosexuality (F66.1 Egodystonic sexual orientation in ICD-10) first entered mental disorders classifications in DSM-III, as part of a negotiation related to removing homosexuality *per se* from that diagnostic system[119]. The compromise was that, while homosexuality itself might not be a disorder, homosexuality could still provide the basis for a psychiatric diagnosis, but only if the individual was distressed about it. This construction was dropped from American Psychiatric Association's classification in 1987[113]. In what appears to have been a parallel process in the subsequent revisions leading to ICD-10, the concept of Egodystonic sexual orientation was incorporated in the ICD-10, approved in 1990, when the ICD-9 diagnostic category for homosexuality *per se* was removed. According to the ICD-10, it is theoretically possible to apply this category to individuals with a heterosexual orientation who wish it were otherwise, but is hard to see this as anything other than an attempt to deflect criticism regarding the purpose of the category[120].

Lesbian, gay, and bisexual individuals often report higher levels of distress than their heterosexual counterparts in international surveys, but this has been linked strongly to experiences of social rejection and stigmatization[114-116]. Because distress related to social adversity cannot be considered as indicative of a mental disorder, any more than can distress related to other socially stigmatized conditions such as poverty or physical illness, the Working Group considered the existence of this distress as lacking in evidentiary value.

F66.2 Sexual relationship disorder in ICD-10 describes a situation in which the individual's sexual orientation (or gender

Table 4 Classification of disorders related to sexual orientation in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[89]
Recommended for deletion	***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Disorders of adult personality and behaviour ***Subgrouping*:** Psychological and behavioural disorders associated with sexual development and orientation	*Not included*	• All categories in this ICD-10 grouping have been recommended for deletion. • These categories or their equivalents are not included in DSM-5, and were not included in DSM-IV. • No scientific interest in these conditions since ICD-10 was published. • No evidence-based treatments. • Working Group determined that these categories confound responses to adverse social circumstances, normal developmental patterns, and psychopathology. • If requirements for depression, anxiety, or another disorder are met, that diagnosis should be used. These diagnoses do not depend on thematic content of associated concerns. • Otherwise, Counselling related to sexuality codes from ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services are more appropriate.
Recommended for deletion	***Category*:** Sexual maturation disorder	*Not included*	• ICD-10 defines category based on uncertainty about gender identity or sexual orientation, which causes anxiety or depression.
Recommended for deletion	***Category***: Egodystonic sexual orientation	*Not included*	• According to ICD-10, should be used when the gender identity or sexual preference is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders.
Recommended for deletion	***Category***: Sexual relationship disorder	*Not included*	• According to ICD-10, should be used when the gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner. • Difficulties in intimate relationships are common, occur for many reasons, and are dyadic. Working Group concluded that there was no justification for category based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.
Recommended for deletion	***Category***: Other psychosexual development disorder	*Not included*	• This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
Recommended for deletion	***Category***: Psychosexual development disorder, unspecified	*Not included*	• This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
Recommended for deletion	***Qualifiers*:** *(May be applied to all categories in grouping)* • *Heterosexual* • *Homosexual* • *Bisexual* • *Other, including prepubertal*	*Not included*	• These categories specify sexual orientation of individual receiving any of the above ICD-10 diagnoses, which are recommended for deletion.

identity) has created a disturbance in a primary sexual relationship. Difficulties in intimate relationships are common, occur for many reasons, and are, by their nature, dyadic. The Working Group concluded that there was no justification for creating a mental disorder category specifically based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.

The Working Group's review concluded that gay, lesbian, and bisexual people receive mental health services for the same reasons that heterosexual people do, and also could find no evidence that concerns about sexual orientation that accompany other mental disorders such as depression or anxiety require different methods of treatment[121]. Further, there are no evidence-based practices related to the F66 categories, and therapeutic attempts to change sexual orientation are considered to be outside the scope of ethical practice[122]. There is also a risk that misattributing symptoms of other mental disorders to conflicts about sexual orientation may interfere with appropriate treatment selection[89].

Moreover, the F66 categories have attracted no scientific interest since the ICD-10 was published. The Working Group conducted a search of Medline, Web of Science, and PsycINFO, and failed to find a single reference to Sexual maturation disorder or Sexual relationship disorder. The last peer-reviewed, indexed reference to "egodystonic homosexuality" was published more than two decades ago. The F66 categories do not

contribute meaningfully to public health surveillance, are not routinely reported by any country, and are not used in WHO's calculation of disease burden. At the same time, they selectively target individuals with same-sex orientation or gender nonconformity, with no apparent justification. Individuals with needs for information or who experience distress specifically related to sexual orientation that is not diagnosable as another disorder (e.g., Adjustment disorder) can still receive services through the use of codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services described earlier in this paper.

The Working Group has therefore proposed the elimination of the entire grouping of F66 disorders from the ICD-11.

Comparison with DSM-5

The proposed changes for ICD-11 in this area bring it in line with DSM-5. No equivalent to any of the ICD-10 F66 categories is included in DSM-5 or was included in DSM-IV.

CONCLUSIONS

In the more than quarter century since the approval of the ICD-10, there have been substantial gains in scientific, clinical, social, and human rights understandings relevant to diagnostic categories related to sexuality and gender identity. These different streams of evidence have been considered in the development of a set of proposals for ICD-11 that departs markedly from the descriptions of categories related to sexuality and gender identity in the ICD-10. The inclusion of mental and behavioural disorders alongside all other diagnostic entities in health care is a central feature of the ICD, and has uniquely positioned the current revision effort to contemplate a broader and more integrative set of classification options with respect to these categories.

The ICD-10 classification of Sexual dysfunctions was substantially outdated in its view of psychological and physical causes of sexual dysfunction as separable and separate, making it inconsistent with current evidence regarding the etiology and treatment of these conditions. For the ICD-11, an innovative, integrated system has been proposed, including a set of qualifiers to indicate the range of factors that the clinician considers to be contributory. It must be emphasized that the WHO does not consider the ICD-11 chapters to constitute scope of practice boundaries between medical specialties, but intends and expects that psychiatrists and other mental health professionals with appropriate training will continue to engage in the treatment of these common and costly conditions and that the reformulated classification of these conditions will encourage broader availability of treatment.

The role of psychiatry in many countries is likely to evolve in substantive ways with respect to the evaluation and treatment of Gender incongruence, proposed to replace Gender identity disorders in the ICD-10. The best health care services for transgender people are by definition multidisciplinary[59]. But psychiatrists in some countries have been unfortunately positioned as gatekeepers to enforce elaborate and burdensome requirements in order to access these services[83], ostensibly in order to verify that transgender people are certain about their decision to seek health services to make their bodies align with their experienced identity. However, in the recent Mexican study described above[71], the average delay between reported awareness of transgender identity and initiation of hormones – by far the most common treatment received – was found to be more than 12 years, and nearly half of participants had initiated hormones without medical supervision, exposing themselves to serious health risks. While these figures are not broadly generalizable, they are likely more reflective of the situation in most of the world than those reported in available studies from the US or Western Europe, given that more that 80% of the global population lives in low- and middle-income countries. Psychiatrists and other mental health professionals have a major role to play in improving the health status of this often mistreated population[58,74,75].

With respect to the classification of Paraphilic disorders, the Working Group on Sexual Disorders and Sexual Health has attempted to grapple with thorny issues related to how best to distinguish between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. At the same time, proposals in this area affirm the status of persistent and intense sexual arousal patterns focusing on individuals who do not or cannot consent as psychiatric in their nature and management[90]. In contrast, the Working Group concluded that there are no legitimate public health or clinical objectives served by mental disorder categories uniquely linked to sexual orientation[89].

In summary, the Working Group on Sexual Disorders and Sexual Health has proposed changes in the classification of these conditions that it considers to be: a) more reflective of current scientific evidence and best practices; b) more responsive to the needs, experience, and human rights of vulnerable populations; and c) more supportive of the provision of accessible and high-quality health care services. Proposed diagnostic guidelines for the disorders described in this paper will be made available for review and comment by members of WHO's Global Clinical Practice Network (http://gcp.network)[123], and subsequently for public review prior to finalization of the ICD-11. We hope that this paper will serve to encourage further scientific and professional discussion.

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