



## Department of Defense on Why Those with “Gender Dysphoria” Are Disqualified from Military Service

*Peter Sprigg*

### EXECUTIVE SUMMARY

Before 2016, persons who identified as “transgender” (those whose psychological “gender identity differs from their biological sex”) were generally disqualified from military service. In 2016, during its last year, the Obama administration reversed that policy. However, in July 2017, President Trump announced he would return to the previous policy, and in March 2018, Defense Secretary James Mattis issued a 44-page “Report and Recommendations” laying out a new policy to exclude those with “gender dysphoria” from the military. Although lower federal courts had blocked implementation of the Trump/Mattis policy in four lawsuits, in January 2019 the U.S. Supreme Court put these lower court rulings on hold, allowing the policy to be implemented pending further litigation.

Three main reasons were cited for the Trump/Mattis policy:

- I. **Mental Health:** “Transgender persons with gender dysphoria suffer from high rates of mental health conditions such as anxiety, depression, and substance use disorders,” as well as “[h]igh rates of suicide ideation, attempts, and completion.” Typical treatments for gender dysphoria have not been shown to restore most patients to a level of mental health comparable to the general population. “Service members with gender dysphoria are eight times more likely to attempt suicide than Service members as a whole . . .” and “nine times more likely to have mental health encounters.”
- II. **Physical Health:** High physical standards are important to the military both because of the demands of combat and because of the need to be available for deployment anywhere in the world at any time without the need for specialized medical care. Cross-sex hormone therapy is an example of specialized care that may not be available everywhere in the world. “Sex reassignment surgery” may require several months of limited duty, depending on the procedure.
- III. **Sex-Based Standards:** “Because [some] sex-based standards are based on legitimate biological differences between males and females, . . . a person’s physical biology should dictate which standards apply.” Making distinctions based on gender identity instead makes no sense. For example, allowing a biological male who still has male anatomy but identifies as female to use female “berthing, bathroom, and shower facilities” undermines the “reasonable expectations of privacy” of biological females. Allowing a biological male who identifies as female to meet female physical fitness standards and compete in athletics with biological females is unfair to other biological males (who must meet a higher standard) *and* to biological females (who may face a safety risk competing against a biological male).

For these reasons, “the Department of Defense concludes that there are substantial risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria . . . [T]he Department also finds that exempting such persons for well-established mental health, physical health, and sex-based standards, which apply to all Service members, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality.”

\*\*\*

### ***Brief Timeline of Military Transgender Policy***

- *Before 2016* – Persons who identify as transgender are generally prohibited from serving in the military.<sup>1</sup>
- *July 1, 2016* – In final year of Obama administration, new policy announced by Defense Secretary Ash Carter takes effect, ending discharges of transgender Service members; will allow those who identify as transgender to join the military beginning July 1, 2017.<sup>2</sup>
- *July 26, 2017* – President Trump announces reversal of the Obama/Carter policy on Twitter, declaring that “the United States Government will not accept or allow Transgender individuals to serve in any capacity in the U.S. Military.”<sup>3</sup>
- *August 25, 2017* – President Trump issues memorandum instructing Secretary of Defense James Mattis to draft policies to implement his decision.<sup>4</sup>
- *August-December, 2017* – Four lawsuits are filed challenging Trump policy; judges in all four cases issue preliminary injunctions against implementation of Trump policy.<sup>5</sup>
- *March 23, 2018* – The White House and Department of Defense release documents laying out a new policy with specific restrictions on military service by some of those who identify as transgender.<sup>6</sup>
- *January 22, 2019* – U.S. Supreme Court agrees to stay (put on hold) the preliminary injunctions in two cases (the third is already dissolved by the U.S. Court of Appeals for the D.C. Circuit, and the fourth, while not yet stayed or dissolved, is thrown into doubt by developments in the other three cases), allowing the Trump/Mattis policy to take effect pending further litigation.<sup>7</sup>

Shortly after the new comprehensive policy was announced in March 2018, Family Research Council published an *Issue Brief*<sup>8</sup> explaining the provisions set forth in the 44-page Department of Defense “Report and Recommendations.”<sup>9</sup> The DoD document defines as “transgender” anyone who experiences “gender incongruity” (“Those persons whose gender identity differs from their biological sex”).<sup>10</sup> The policy toward individuals with gender incongruity is dependent upon:

- whether they have been formally diagnosed with the mental condition known as “gender dysphoria” (“Discomfort with their biological sex, resulting in significant distress or difficulty functioning”<sup>11</sup>);
- whether they have undertaken a “gender transition” (the process whereby a person changes from publicly identifying with and living as their biological sex to living as their preferred gender); and
- when they joined the military, received their gender dysphoria diagnosis (if any), and initiated their transition (if any), in relation to when the Obama/Carter policy took effect and when the Trump policy takes effect.

Unfortunately, this new Trump administration policy did not take effect when it was issued, due to the injunctions against it in the four lawsuits. However, on January 4, 2019, a three-judge panel of the D.C.

Circuit issued a short (five-page) ruling saying that the preliminary injunction in one of the cases should be dissolved and vacated.<sup>12</sup> Then on January 22, the U.S. Supreme Court stayed preliminary injunctions in two other cases, finally allowing the Trump/Mattis policy to take effect, pending further litigation.<sup>13</sup> Although we must await more decisions from the courts, the D.C. Circuit and Supreme Court decisions give hope that in the end, the Supreme Court and lower federal courts will defer to the legitimate power of the executive branch to set military policy.

Most of the news media have done a poor job of explaining the compelling rationale for the new policy that was set forth in great detail in the 44-page DoD “Report and Recommendations.” This paper seeks to rectify that by presenting excerpts and a condensed explanation of why those with gender dysphoria should generally be disqualified from military service.

## **Military Values at Stake**

In a three-page memorandum with which Defense Secretary Mattis transmitted the “Report and Recommendations” to President Trump on February 22, 2018, he identified a number of values that must take priority when making military personnel policy. These included:

- “readiness”
- “lethality”
- “military effectiveness”
- “unit cohesion”
- “military resources”<sup>14</sup>

In determining the impact that allowing transgender Service members might have on the military, there were three primary considerations and bodies of data that shaped the final decision. They related to:

- Mental Health
- Physical Health; and
- Sex-Based Standards.

Let’s examine each of these in turn.

## **I. Mental Health**

### **Importance of Mental Health Standards**

The DoD “Report and Recommendations” explain why mental health standards are important to the military:

Given the extreme rigors of military service and combat, maintaining high standards of mental health is essential to military effectiveness and lethality. The immense toll that the burden and experience of combat can have on the human psyche cannot be overstated. Therefore, putting individuals into battle, who might be at increased risk of psychological injury, would be reckless, not only for those individuals, but for the Service members who serve beside them as well . . .

Most mental health conditions and disorders are automatically disqualifying for accession absent a waiver. For example, persons with a history of bipolar disorder, personality disorder, obsessive-compulsive disorder, suicidal behavior, and even body dysmorphic disorder (to name a few) are barred from entering into military service, unless a waiver is granted.<sup>15</sup>

## **Transgender Mental Health Problems**

The report then goes on to cite some of the existing research regarding mental health problems associated with gender dysphoria:

Transgender persons with gender dysphoria suffer from high rates of mental health conditions such as anxiety, depression, and substance use disorders. High rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature, with lifetime rates of suicide attempts reported to be as high as 41% (compared to 4.6% for the general population).<sup>16</sup>

Again, the document notes the unique challenges this can pose in a military environment:

The Department is concerned that the stresses of military life, including basic training, frequent moves, deployment to war zones and austere environments, and the relentless physical demands, will be additional contributors to suicide behavior in people with gender dysphoria. In fact, there is recent evidence that military service can be a contributor to suicidal thoughts.<sup>17</sup>

## **Findings Regarding Existing Transgender Service Members**

One thing unique about the “Report and Recommendations” is that they made public, for the first time ever, data regarding the actual experience of the U.S. military with transgender Service members since the Obama/Carter policy took effect on July 1, 2016. This information was not available for previous analyses of this issue, such as the RAND Corporation report that was relied upon by Defense Secretary Ash Carter.<sup>18</sup>

Here is a sample:

A review of the administrative data indicates that Service members with gender dysphoria are eight times more likely to attempt suicide than Service members as a whole (12% versus 1.5%). Service members with gender dysphoria are also nine times more likely to have mental health encounters than the Service member population as a whole (28.1 average encounters per Service member versus 2.7 average encounters per Service member). From October 1, 2015 to October 3, 2017, the 994 active duty Service members diagnosed with gender dysphoria accounted for 30,000 mental health visits.<sup>19</sup>

## **Treatment of Gender Dysphoria**

Pro-transgender activists argue, of course, that gender dysphoria can (and should) be treated, and that with appropriate treatment, both the dysphoria itself and other mental health problems can be alleviated. However, rather than using psychotherapy or counselling, the treatment they often prefer is medical, such as the use of cross-sex hormones and gender reassignment surgery.

The DoD “Report and Recommendations” caution that “there is considerable scientific uncertainty concerning whether these treatments fully remedy, even if they may reduce, the mental health problems associated with gender dysphoria.”<sup>20</sup>

Several examples from scholarly studies and reviews of the research are cited:

As recently as August 2016, the Centers for Medicare and Medicaid Services (CMS) . . . concluded that there was “not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria . . .”

. . . According to [CMS], “the four best designed and conducted studies . . . did not demonstrate clinically significant changes or differences in psychometric test results after [sex reassignment surgery].”<sup>21</sup>

One notable study out of Sweden was cited:

. . . [It] is one of the most robust because it is a “nationwide population-based, long-term follow-up of sex-reassigned transsexual persons.” The study found increased mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group. As described by CMS: “The mortality was primarily due to completed suicides (19.1-fold greater than in [the control group]), . . . The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%). The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control.”<sup>22</sup>

The report also cited the *Hayes Directory*, which is “a comprehensive collection of in-depth health technology assessment reports”<sup>23</sup> used “to support the development of coverage policies and best practices for healthcare payers and providers”<sup>24</sup>:

Hormone therapy and subsequent [sex reassignment surgery] failed to bring overall mortality, suicide rates, or death from illicit drug use in [male-to-female] patients close to rates observed in the general male population.<sup>25</sup>

The DoD also cited data on suicide attempts compiled by researchers from the highly-respected Mayo Clinic<sup>26</sup>:

In 2010, Mayo Clinic researchers conducted a comprehensive review of 28 studies on the use of cross-sex hormone therapy in sex reassignment . . . Importantly, however, “[s]uicide attempt rates decreased after sex reassignment but stayed higher than the normal population rate.”<sup>27</sup>

## **The Challenge for Readiness**

The “Report and Recommendations” explain in more detail how such mental health issues may affect military readiness:

. . . [M]ost mental health conditions, as well as the medication to treat them, limit Service members’ ability to deploy. Any DSM-5<sup>28</sup> psychiatric disorder with residual symptoms, or medication side effects, which impair social or occupational performance, require[s] a waiver for the Service member to deploy. The same is true for mental health conditions that pose a substantial risk for deterioration or recurrence in the deployed environment. In managing mental health conditions while deployed, providers must consider the risk of exacerbation if the individual were exposed to trauma or severe operational stress.<sup>29</sup>

Advocates of allowing transgender Service members, such as the authors of the 2016 RAND Corporation report, argue that the *overall* impact on the military would be small because the *number* of Service

members with gender dysphoria is so low. The “Report and Recommendations” respond with a comparison to other mental health conditions:

. . . RAND concluded that the impact on readiness would be minimal . . . because of the exceedingly small number of transgender Service members who would seek transition-related treatment . . . Nevertheless, by RAND’s standard, the readiness impact of many medical conditions that the Department has determined to be disqualifying – from bipolar disorder to schizophrenia – would be minimal because they, too, exist only in relatively small numbers. And yet that is no reason to allow persons with those conditions to serve.<sup>30</sup>

The DoD summarized these findings regarding mental health and their implications for military service:

As explained earlier in greater detail, persons with gender dysphoria experience significant distress and impairment in social, occupational, or other important areas of functioning. Gender dysphoria is also accompanied by extremely high rates of suicidal ideation and other comorbidities. Therefore, to ensure unit safety and mission readiness, which is essential to military effectiveness and lethality, persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces.<sup>31</sup>

### **The Issue: *Full Mental Health***

Although it is implicit in several of the citations above, let me reiterate: the issue for the military is not whether permitting Service members to undergo gender transition will result in *some* improvement in mental health. Given some of the data above (especially the shocking post-surgical suicide rates reported in the Swedish study), it is unclear whether even that has been proven.

However, even if gender transition alleviates the actual *gender dysphoria* of some individuals, it may not eliminate (or even alleviate) all the *other* psychological conditions that accompany such dysphoria. And even if some studies give evidence that gender transition does result in an *incremental* improvement in *overall* well-being, there appears to be little if any evidence that such interventions can bring those with gender dysphoria to a level of mental health that is *comparable to the general population*. Yet only that level (or better, given the unique demands) would be adequate for military service. As the “Report and Recommendations” warn:

. . . [G]iven the vital interests at stake – the survivability of Service members, including transgender persons, in combat and the military effectiveness and lethality of our forces – it is prudent to proceed with caution, especially in light of the inconclusive scientific evidence that transition-related treatment restores persons with gender dysphoria to *full mental health*”<sup>32</sup> (emphasis added).

## **II. Physical Health**

### **Importance of Physical Health Standards**

As with the mental health standards, the DoD “Report and Recommendations” explained in detail why the military maintains high physical standards:

Not only is maintaining high standards of mental health critical to military effectiveness and lethality, maintaining high standards of physical health is as well. Although technology has done much to ease the physical demands of combat in some military specialties, war very much remains a physically demanding endeavor. Service members must therefore be physically prepared to endure the rigors and hardships of military service, including potentially combat. They must be able to carry heavy equipment sometimes over long distances; they must be able to handle heavy machinery; they must be able to traverse harsh terrain or survive in ocean waters; they must be able to withstand oppressive heat, bitter cold, rain, sleet, and snow; they must be able to endure in unsanitary conditions, coupled with lack of privacy for basic bodily functions, sometimes with little sleep and sustenance; they must be able to carry their wounded comrades to safety; and they must be able to defend themselves against those who wish to kill them.<sup>33</sup>

The paragraph above addresses the importance of high physical standards to the successful performance of military tasks when the Service member is deployed, particularly in combat. Even prior to that, however, is the need for good physical health so that the individual is available for deployment in the first place. When we talk about the threat posed to “military readiness” posed by allowing transgender Service members, the concern is primarily about the individual’s deployability:

Above all, whether they serve on the frontlines or in relative safety in non-combat positions, every Service member is important to mission accomplishment and must be available to perform their duties globally whenever called upon. The loss of personnel due to illness, disease, injury, or bad health diminishes military effectiveness and lethality. The Department’s physical health standards are therefore designed to minimize the odds that any given Service member will be unable to perform his or her duties in the future because of illness, disease, or injury. As noted earlier, those who seek to enter military service must be free of contagious diseases; free of medical conditions or physical defects that could require treatment, hospitalization, or eventual separation from service for medical unfitness; medically capable of satisfactorily completing required training; medically adaptable to the military environment; and medically capable of performing duties without aggravation of existing physical defects or medical conditions. To access recruits with higher rates of anticipated unavailability for deployment thrusts a heavier burden on those who would deploy more often.<sup>34</sup>

### **Impact of Cross-Sex Hormone Therapy**

The definitions used in the DoD “Report and Recommendations” have been brought up to date (compared to the pre-2016 policy) to be consistent with those used by the American Psychiatric Association. Under those definitions, not all “transgender” persons (those with “gender incongruity”) suffer from “gender dysphoria;” not everyone with gender dysphoria undertakes a “gender transition” (to presenting publicly in accordance with their “gender identity” rather than their biological sex. Types of “transition” can also vary:

Transition-related treatment is highly individualized and could involve what is known as a “medical transition,” which includes cross-sex hormone therapy, or a “surgical transition,” which includes sex reassignment surgery. Service members could also forego medical transition treatment altogether, retain all of their biological anatomy, and live as the opposite gender — this is called a “social transition.”<sup>35</sup>

However, the use of cross-sex hormones (such as estrogen for a biological male who identifies as female, or testosterone for a biological female who identifies as male) is quite common among those who

transition. Yet hormone therapy is precisely the kind of specialized treatment that may not be available everywhere in the world, which thus may limit deployability:

Endocrine Society guidelines for cross-sex hormone therapy recommend quarterly bloodwork and laboratory monitoring of hormone levels during the first year of treatment. Of the 424 approved Service member treatment plans available for study, almost all of them – 91.5% – include the prescription of cross-sex hormones . . . If the operational environment does not permit access to a lab for monitoring hormones (and there is certainly debate over how common this would be), then the Service member must be prepared to forego treatment, monitoring, or the deployment. Either outcome carries risks for readiness.<sup>36</sup>

A footnote later in the DoD “Report and Recommendations” quoted a 2016 article in the journal *Military Medicine* which elaborated on the challenge that a gender dysphoria diagnosis leading to hormone therapy could present:

As previously discussed, a new diagnosis of gender dysphoria and the decision to proceed with gender transition requires frequent evaluations by the [mental health professional] and endocrinologist. However, most [military treatment facilities] lack one or both of the specialty services. Members who are not in proximity to [military treatment facilities] may have significant commutes to reach their required specialty care. Members stationed in more remote locations face even greater challenges of gaining access to military or civilian specialists within a reasonable distance from their duty stations.<sup>37</sup>

Forgoing hormone therapy in order to deploy – even after it has been deemed “medically necessary” (a prerequisite even under the Obama/Carter policy) – could cause its own problems:

[S]ome experts in endocrinology . . . found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use. Of course, postponing treatment, especially during a combat deployment, has risks of its own insofar as the treatment is necessary to mitigate the clinically significant distress and impairment of functioning caused by gender dysphoria. After all, “when Service members deploy and then do not meet medical deployment fitness standards, there is risk for inadequate treatment within the operational theater, personal risk due to potential inability to perform combat required skills, and the potential to be sent home from the deployment and render the deployed unit with less manpower.”<sup>38</sup>

### **Impact of Gender Reassignment Surgery**

Although fewer transgender Service members may pursue gender reassignment surgery than hormones, the impact on the deployability of those who do is even greater than with hormones alone. The DoD “Report and Recommendations” list an astonishing 24 separate surgical procedures that are authorized under the Obama/Carter policy.<sup>39</sup> The document then notes the recovery time for several of them:

The estimated recovery time for each of the surgical procedures, even assuming no complications, can be substantial. For example, assuming no complications, the recovery time for a hysterectomy [removal of the uterus] is up to eight weeks; a mastectomy [removal of the breasts] is up to six weeks; a phalloplasty [creation of an artificial penis] is up to three months; a metoidioplasty [expansion of the clitoris to resemble a penis] is up to eight weeks; an orchiectomy [removal of the testicles] is up to six weeks; and a vaginoplasty [creation of an



artificial vagina] is up to three months. When combined with 12 continuous months of hormone therapy, which is required prior to genital surgery, the total time necessary for surgical transition can exceed a year.<sup>40</sup>

Thus, significant duty time may be lost even if such surgeries go as planned. However, they also carry a risk of complications:

... [T]he rate of complications for these surgeries is significant, which could increase a transitioning Service member's unavailability. Even according to the RAND study, 6% to 20% of those receiving vaginoplasty surgery experience complications, meaning that "between three and 11 Service members per year would experience a long-term disability from gender reassignment surgery." The RAND study further notes that of those receiving phalloplasty surgery, as many as 25% – one in four – will have complications.<sup>41</sup>

Research has identified other physical health risks for post-surgical transgender patients beyond those directly attributable to the surgery itself. The Swedish study which showed high levels of suicide among that population also found that "death due to neoplasm [cancer] and cardiovascular disease was increased 2 to 2.5 times as well."<sup>42</sup>

### **Findings Regarding Deployability of Existing Transgender Service Members**

The DoD's Panel of Experts heard conflicting views regarding "the impact on readiness of allowing gender transition." However:

... [S]ome commanders with transgender Service members reported that, from the time of diagnosis to the completion of a transition plan, the transitioning Service members would be non-deployable for two to two-and-a-half years.<sup>43</sup>

The limited data so far collected on existing transgender Service members undergoing gender transition under the Obama/Carter policy has shown that it results in considerable lost service time – an average of more than five months per person:

Although limited and incomplete because many transitioning Service members either began treatment before the Carter policy took effect or did not require sex reassignment surgery, currently available in-service data already show that, cumulatively, transitioning Service members in the Army and Air Force have averaged 167 and 159 days of limited duty, respectively, over a one-year period.<sup>44</sup>

Even the RAND study acknowledged that gender transition treatments may limit the deployability of individual Service members. As described by the DoD "Report and Recommendations":

The RAND study acknowledges that the inclusion of individuals with gender dysphoria will have a negative impact on readiness. According to RAND, foreign militaries that allow service by personnel with gender dysphoria have found that it is sometimes necessary to restrict the deployment of transitioning individuals, including those receiving hormone therapy and surgery, to austere environments where their healthcare needs cannot be met.<sup>45</sup>

### **Inequity of More Favorable Treatment of Transgender Patients**

Although transgender activists argue that placing limits on transgender military service unfairly discriminates against those who experience gender dysphoria, the “Report and Recommendations” point out that the Obama/Carter policy actually discriminates *in favor of* people receiving hormones or surgery for the purpose of gender transition, when compared to people who have undergone comparable treatments or procedures for other conditions. For example:

Historically, absent a waiver, the Department has barred from accessing into the military anyone who had undergone chest or genital surgery (e.g., removal of the testicles or uterus) and anyone with a history of major abnormalities or defects of the chest or genitalia, including hermaphroditism and pseudohermaphroditism. Persons with conditions requiring medications, such as anti-depressants and hormone treatment, were also disqualified from service, unless a waiver was granted.

These standards have long applied uniformly to all persons, regardless of transgender status. The Carter policy, however, deviates from these uniform standards by exempting, under certain conditions, treatments associated with gender transition, such as sex reassignment surgery and cross-sex hormone therapy. For example, under the Carter policy, an applicant who has received genital reconstruction surgery may access without a waiver if a period of 18 months has elapsed since the date of the most recent surgery, no functional limitations or complications persist, and no additional surgery is required. In contrast, an applicant who received similar surgery following a traumatic injury is disqualified from military service without a waiver. Similarly, under the Carter policy, an applicant who is presently receiving cross-sex hormone therapy post-gender transition may access without a waiver if the applicant has been stable on such hormones for 18 months. In contrast, an applicant taking synthetic hormones for the treatment of hypothyroidism is disqualified from military service without a waiver.<sup>46</sup>

### III. Sex-Based Standards

In addition to concerns about the mental health problems that are often co-occurring with gender dysphoria and the physical health problems that can result from treatments such as cross-sex hormones and gender reassignment surgery, the third major basis for the Trump/Mattis policy is the realistic necessity and legitimate existence of certain “sex-based standards” – that is, standards that are logically defined by the individual’s biological sex at birth and/or physical anatomy, not by one’s psychological gender identity.

The DoD “Report and Recommendations” point out:

The vast majority of military standards make no distinctions between men and women. Where biological differences between males and females are relevant, however, military standards do differentiate between them.<sup>47</sup>

Since they are based on biology, it simply makes no sense to replace standards defined in terms of biological sex with ones defined in terms of gender identity instead:

Because these sex-based standards are based on legitimate biological differences between males and females, it follows that a person’s physical biology should dictate which standards apply. Standards designed for biological males logically apply to biological males, not biological females, and vice versa . . .

. . . [U]nder the [Obama/]Carter policy, a biological male who identifies as a female (and changes his gender marker to reflect that gender) must be held to the standards and regulations for females, even though those standards and regulations are based on female physical biology, not female gender identity. The same goes for females who identify as males. Gender identity alone, however, is irrelevant to standards that are designed on the basis of biological differences.<sup>48</sup>

## Privacy

For example, such standards exist with respect to the type of facilities that are typically separated between men and women, due to “anatomical differences between males and females,”<sup>49</sup> out of a concern for privacy from the opposite sex:

. . . Given the unique nature of military service, Service members of the same biological sex are often required to live in extremely close proximity to one another when sleeping, undressing, showering, and using the bathroom. Because of reasonable expectations of privacy, the military has long maintained separate berthing, bathroom, and shower facilities for men and women while in garrison. In the context of recruit training, this separation is even mandated by Congress.<sup>50</sup>

It might be argued that if the transgender Service member has undergone surgical procedures to make his or her body resemble that of the opposite biological sex, then he or she should fit in well in the facilities of the preferred gender. However, it is important to remember that not all persons with gender dysphoria obtain gender reassignment surgery (in fact, most diagnosed in the military since 2016 have *not* obtained it), and obtaining such surgery is not a condition for a Service member to be treated as the opposite sex under the Obama/Carter policy:

Rather than apply only to those transgender individuals who have altered their external biological characteristics to fully match that of their preferred gender, under the Carter policy, persons need not undergo sex reassignment surgery, or even cross-sex hormone therapy, in order to be recognized as, and thus subject to the standards associated with, their preferred gender. A male who identifies as female could remain a biological male in every respect and still be treated in all respects as a female, including with respect to physical fitness, facilities, and uniform and grooming . . . [O]f the 424 approved Service member treatment plans available for study, 388 included cross-sex hormone treatment, but only 34 non-genital sex reassignment surgeries and one genital surgery have been completed thus far. Only 22 Service members have requested a waiver for a genital sex reassignment surgery.<sup>51</sup>

Allowing Service members who have not undergone a transition to use the facilities of their preferred gender could undermine key military values:

. . . [A] policy that accommodates gender transition without requiring full sex reassignment surgery could also erode reasonable expectations of privacy that are important in maintaining unit cohesion, as well as good order and discipline.

. . . Allowing transgender persons who have not undergone a full sex reassignment, and thus retain at least some of the anatomy of their biological sex, to use the facilities of their identified gender would invade the expectations of privacy that the strict male-female demarcation in berthing, bathroom, and shower facilities is meant to serve.<sup>52</sup>

In fact, pitting the demands of transgender Service members against the legitimate privacy concerns of the majority (especially of biologically female Service members who are not transgender) creates irreconcilable conflicts – as the DoD showed in recounting this incident:

The best illustration of this irreconcilability is the report of one commander who was confronted with dueling equal opportunity complaints – one from a transgender female (i.e., a biological male with male genitalia who identified as female) and the other from biological females. The transgender female Service member was granted an exception to policy that allowed the Service member to live as a female, which included giving the Service member access to female shower facilities. This led to an equal opportunity complaint from biological females in the unit who believed that granting a biological male, even one who identified as female, access to their showers violated their privacy. The transgender Service member responded with an equal opportunity complaint claiming that the command was not sufficiently supportive of the rights of transgender persons.

The collision of interests discussed above are a direct threat to unit cohesion and will inevitably result in greater leadership challenges without clear solutions.<sup>53</sup>

### **Physical Fitness**

The military also has different standards for men and women regarding physical fitness that are entirely based on anatomical differences between biological males and biological females:

In addition, physiological differences between males and females account for the different physical fitness and body fat standards that apply to men and women. This ensures equity and fairness. Likewise, those same physiological differences also account for the policies that regulate competition between men and women in military training and sports, such as boxing and combatives. This ensures protection from injury.<sup>54</sup>

The DoD goes on to explain how deviating from biological sex-based standards could undermine both fairness and safety:

It could be perceived as discriminatory to apply different biologically-based standard to persons of the same biological sex based on gender identity, which is irrelevant to standards grounded in physical biology. For example, it unfairly discriminates against biological males who identify as male and are held to male standards to allow biological males who identify as female to be held to female standards, especially where the transgender female retains many of the biological characteristics and capabilities of a male.<sup>55</sup>

While this illustration (a biological male who identifies as female being held to female standards) is unfair to other biologically male Service members who must meet a higher standard, it can also pose a risk for biologically female Service members:

Biological females who may be required to compete against transgender females in training and athletic competition would potentially be disadvantaged. Even more importantly, in physically violent training and competition, such as boxing and combatives, pitting biological females against biological males who identify as female, and vice versa, could present a serious safety risk as well.<sup>56</sup>

Footnotes in the DoD “Report and Recommendations” explain in greater detail the type of physical and athletic activities in which these concerns might come into play. An army regulation on “Enlisted Initial Entry Training” notes, “Performance requirement differences, such as [Army Physical Fitness Test] scoring are based on physiological differences, and apply to the entire Army.” As an example, to graduate from the U.S. Military Academy, “cadets must meet the minimum performance standard of 3:30 for men and 5:29 for women on the Indoor Obstacle Course Test” – a significant difference.<sup>57</sup>

West Point has also recently integrated women into mandatory boxing classes. The DoD cites a detailed article about this process which noted that even though boxing competitions are grouped by weight (thus mitigating any advantage biological males have by being, on average, larger than biological females), “[m]atching men and women according to weight may not adequately account for gender differences regarding striking force,” and therefore that “[w]hile conducting free sparring, cadets must box someone of the same gender.”<sup>58</sup>

There is one other inequity that would arise from not adhering strictly to standards based on biological sex, although it is not mentioned explicitly in the DoD “Report and Recommendations.” As noted, physical fitness standards are generally higher for biological males than for biological females. If a biological male transitions to a female identity and is then held to female standards (as under the Obama/Carter policy), that individual has an advantage over other biological males (because of being held to lower standards) and a competitive advantage over biological females (because of having a male anatomy).

If, however, a biologically female Service member seeks to transition to a male identity, the opposite is the case. Such an individual would be at a *disadvantage* relative to other biologically female Service members (because of having to meet the higher male standards), while also being at a competitive *disadvantage* relative to biologically male Service members (because of having a female anatomy).

In other words, ironically, the Obama/Carter policy, which sought to eliminate “discrimination” against transgender Service members, is itself discriminatory. It discriminates *in favor of* male-to-female transgender Service members, and discriminates *against* female-to-male transgender Service members.<sup>59</sup>

### **Uniform and Grooming Standards**

Although perhaps not as critical as the privacy and physical fitness standards, allowing transgender Service members to serve as their preferred gender creates an inconsistency regarding uniform and grooming standards as well:

Uniform and grooming standards, to a certain extent, are also based on anatomical differences between males and females. Even those uniform and grooming standards that are not, strictly speaking, based on physical biology nevertheless flow from longstanding societal expectations regarding differences in attire and grooming for men and women.<sup>60</sup>

Again, issues of fairness come into play:

By allowing a biological male to adhere to female uniform and grooming standards, it creates unfairness for other males who would also like to be exempted from male uniform and grooming standards as a means of expressing their own sense of identity.<sup>61</sup>

### **Summary Regarding Sex-Based Standards**

All of these issues create challenges that would be an excessive burden on military leaders:

The collision of interests discussed above are a direct threat to unit cohesion and will inevitably result in greater leadership challenges without clear solutions. Leaders at all levels already face immense challenges in building cohesive military units. Blurring the line that differentiates the standards and policies applicable to men and women will only exacerbate those challenges and divert valuable time and energy from military tasks.

The unique leadership challenges arising from gender transition are evident in the Department's handbook implementing the Carter policy. The handbook provides guidance on various scenarios that commanders may face . . .

These vignettes illustrate the significant effort required of commanders to solve challenging problems posed by the implementation of the current transgender service policies. The potential for discord in the unit during routine execution of daily activities is substantial and highlights the fundamental incompatibility of the Department's legitimate military interest in uniformity, the privacy interests of all Service members, and the interest of transgender individuals in appropriate accommodation. Faced with these conflicting interests, commanders are often forced to devote time and resources to resolve issues not present outside of military service.<sup>62</sup>

The "Report and Recommendations" summarize how sex-based standards advance military values:

As discussed in detail earlier, military personnel policy has long maintained a clear line between men and women where their biological differences are relevant with respect to physical fitness and body fat standards; berthing, bathroom, and shower facilities; and uniform and grooming standards. This line promotes good order and discipline, steady leadership, unit cohesion, and ultimately military effectiveness and lethality because it ensures fairness, equity, and safety; satisfies reasonable expectations of privacy; reflects common practice in the society from which we recruit; and promotes core military values of dignity and respect between men and women. To exempt Service members from the uniform, biologically-based standards applicable to their biological sex on account of their gender identity would be incompatible with this line and undermine the objectives such standards are designed to serve.<sup>63</sup>

#### **IV. Costs**

Although not addressed in as great a level of detail as other issues, the DoD "Report and Recommendations" also warn that allowing taxpayer-funded gender transitions for Service members "imposes disproportionate costs." The document reports:

Transition-related treatment is also proving to be disproportionately costly on a per capita basis, especially in light of the absence of solid scientific support for the efficacy of such treatment. Since implementation of the [Obama/]Carter policy, the medical costs for Service members with gender dysphoria have increased nearly three times – or 300% – compared to Service member without gender dysphoria. And this increase is despite the low number of costly sex reassignment surgeries that have been performed so far. As noted earlier, only 34 non-genital sex reassignment surgeries and one genital surgery have been completed, with an additional 22 Service members requesting a waiver for genital surgery. We can expect the cost disparity to grow as more Service members diagnosed with gender dysphoria avail themselves of surgical treatment. As many as 77% of the 424 Service member treatment plans available for review

include requests for transition-related surgery . . . In addition, several commanders reported to the Panel of Experts that transition-related treatment for Service members with gender dysphoria in their units had a negative budgetary impact because they had to use operations and maintenance funds to pay for the Service members' extensive travel throughout the United States to obtain specialized medical care.<sup>64</sup>

While the "Report and Recommendations" focus only on per capita costs, Family Research Council had previously attempted to estimate what the cumulative cost of the Obama/Carter transgender military policy might be. We concluded that the cost could be as high as \$1.9 to \$3.7 billion over the next ten years. Administrative costs could drive the total even higher:

This total includes both direct medical costs and the cost of potential lost time of deployable service. (The additional administrative costs of preparing and overseeing individualized care plans for each service member who identifies as transgender, the costs of training the entire force regarding the new policy, and the loss of time associated with that training, have *not* been included in these estimates.)<sup>65</sup>

## Conclusion

Defense Secretary Mattis summarized these findings in his February 22, 2018 memorandum transmitting the "Report and Recommendations" to President Trump:

Based on the work of the Panel [of Experts] and the Department's best military judgment, the Department of Defense concludes that there are substantial risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria and [who] require, or have already undertaken, a course of treatment to change their gender. Furthermore, the Department also finds that exempting such persons for well-established mental health, physical health, and sex-based standards, which apply to all Service members, including transgender Service members without gender dysphoria, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality.<sup>66</sup>

As should be evident from this paper, there is abundant evidence in support of that conclusion.

*Peter Sprigg is Senior Fellow for Policy Studies at Family Research Council in Washington, D.C.*

---

<sup>1</sup> Peter Sprigg, "Should Individuals Who Identify as Transgender Be Permitted to Serve in the Military?" Family Research Council, September 2016, <https://downloads.frc.org/EF/EF16B37.pdf>.

<sup>2</sup> "Memorandum for Secretaries of the Military Departments," Secretary of Defense, June 30, 2016, [https://dod.defense.gov/Portals/1/features/2016/0616\\_policy/DTM-16-005.pdf](https://dod.defense.gov/Portals/1/features/2016/0616_policy/DTM-16-005.pdf).

<sup>3</sup> Jacob Pramuk, "Trump says his administration will block transgender people from serving in the military," CNBC.com, July 26, 2017, accessed January 28, 2019, <https://www.cnbc.com/2017/07/26/trump-will-block-transgender-people-from-serving-in-the-military.html>.

<sup>4</sup> "Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security," The White House, August 25, 2017, accessed January 28, 2019, <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-secretary-defense-secretary-homeland-security/>.

- 
- <sup>5</sup> Maria Perez, “Trump’s Transgender Military Ban is Being Legally Challenged,” *Newsweek*, January 27, 2018, accessed January 28, 2019, <https://www.newsweek.com/transgender-military-ban-transgender-rights-president-donald-trump-us-793075>.
- <sup>6</sup> “Mattis Memorandum”; “Department of Defense Report and Recommendations on Military Service by Transgender Persons (Feb. 2018)”; “Presidential Memorandum,” [https://drive.google.com/file/d/1orvILU5VJ2EkrHSDCBVBmv8t\\_V6sbne9/view](https://drive.google.com/file/d/1orvILU5VJ2EkrHSDCBVBmv8t_V6sbne9/view).
- <sup>7</sup> “US Supreme Court allows Trump military transgender ban,” BBC News, January 22, 2019, accessed January 28, 2019, <https://www.bbc.com/news/world-us-canada-46963426>.
- <sup>8</sup> Peter Sprigg, “Summary of Trump Administration Policy on Transgender Military Service,” Family Research Council, April 2018, <https://downloads.frc.org/EF/EF18D10.pdf>.
- <sup>9</sup> “Department of Defense Report and Recommendations on Military Service by Transgender Persons,” February 2018, <https://media.defense.gov/2018/Mar/23/2001894037/-1/-1/0/MILITARY-SERVICE-BY-TRANSGENDER-INDIVIDUALS.PDF>.
- <sup>10</sup> James N. Mattis, “Military Service by Transgender Individuals,” Memorandum for the President, February 22, 2018, <https://media.defense.gov/2018/Mar/23/2001894037/-1/-1/0/MILITARY-SERVICE-BY-TRANSGENDER-INDIVIDUALS.PDF>, 1. Note that “gender identity,” like “sexual orientation,” is a multi-faceted phenomenon that involves subjective feelings, objective behaviors, and self-identification. Family Research Council has adopted a stylistic norm of usually referring to individuals explicitly on the basis of their self-identification (e.g., “those who identify as gay” or “those who identify as transgender”) to avoid what we believe to be a false implication that the related feelings are inborn or innate. However, for purposes of this paper, we will use the term “transgender” as it is used in the DoD “Report and Recommendations,” as a reference to all those who experience the *feeling* of gender incongruity. Such individuals may or may not be formally diagnosed with “gender dysphoria,” may or may not undertake a gender transition (behavior), and even may or may not explicitly identify themselves as “transgender” (self-identification).
- <sup>11</sup> *Ibid.*
- <sup>12</sup> *Doe 2 v. Shanahan*, USCA Case #18-5257 (D.C. Cir. 2019) (per curiam), <https://notransmilitaryban.org/wp-content/uploads/2019/01/doe-v-trump-dc-circuit-ruling-1-4-19.pdf>.
- <sup>13</sup> Adam Liptak, “Supreme Court Revives Transgender Ban for Military Service,” *The New York Times*, January 22, 2019, accessed February 1, 2019, <https://www.nytimes.com/2019/01/22/us/politics/transgender-ban-military-supreme-court.html>.
- <sup>14</sup> Mattis, 1.
- <sup>15</sup> “Report and Recommendations,” 19-20.
- <sup>16</sup> *Ibid.*, 21. (Note: The DoD “Report and Recommendations” are heavily footnoted with sources supporting each statement – a total of 166 footnotes in the 44-page document. Most of those citations will be omitted in the excerpts quoted in this paper, unless the note adds substantive information.)
- <sup>17</sup> *Ibid.*
- <sup>18</sup> Agnes Gereben Schaefer, et al., “Assessing the Implications of Allowing Transgender Personnel to Serve Openly,” RAND Corporation, 2016, [https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR1500/RR1530/RAND\\_RR1530.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1530/RAND_RR1530.pdf).
- <sup>19</sup> “Report and Recommendations,” 21-22.
- <sup>20</sup> *Ibid.*, 32.
- <sup>21</sup> *Ibid.*, 24; citing Tamara Jensen, et al., “Decision Memo for Gender Dysphoria and Gender Reassignment Surgery,” Centers for Medicare & Medicaid Services, <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282>.
- <sup>22</sup> “Report and Recommendations,” 25; citing Cecilia Dhejne, et al., “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden,” *PLoS ONE* 6 (2011), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>.
- <sup>23</sup> “Medical Technology Directory,” Hayes, Inc., accessed February 1, 2019, <https://www.hayesinc.com/hayes/publications/medical-technology-directory/>.
- <sup>24</sup> Hayes, Inc., “Hayes, Inc. Medical Technology Directory Celebrates Its 25th Year,” press release, October 25, 2016, <https://www.hayesinc.com/hayes/news-room/press-releases/hayes-inc-medical-technology-directory-celebrates-its-25th-year/>.
- <sup>25</sup> “Report and Recommendations,” 26.



---

<sup>26</sup> Avery Comarow and Ben Harder, “2018-19 Best Hospitals Honor Roll and Medical Specialties Rankings,” *U.S. News & World Report*, August 14, 2018, accessed January 11, 2019, <https://health.usnews.com/health-care/best-hospitals/articles/best-hospitals-honor-roll-and-overview>.

<sup>27</sup> “Report and Recommendations,” 26.

<sup>28</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-5* (Washington, D.C.: American Psychiatric Publishing, 2013).

<sup>29</sup> “Report and Recommendations,” 34.

<sup>30</sup> *Ibid.*, 34-35.

<sup>31</sup> *Ibid.*, 42.

<sup>32</sup> *Ibid.*, 40-41.

<sup>33</sup> *Ibid.*, 27.

<sup>34</sup> *Ibid.*

<sup>35</sup> *Ibid.*, 7-8.

<sup>36</sup> *Ibid.*, 33.

<sup>37</sup> Irene Folaron & Monica Lovasz, “Military Considerations in Transsexual Care of the Active Duty Member,” *Military Medicine* 181, (Oct. 2016): 1185; cited in “Report and Recommendations,” 41, footnote 164.

<sup>38</sup> *Ibid.*, 34; quoting an analysis regarding the possibility of recruiting individuals with another condition, “auditory impairment.”

<sup>39</sup> “Report and Recommendations,” 22-23.

<sup>40</sup> *Ibid.*, 23.

<sup>41</sup> *Ibid.*, 23-24.

<sup>42</sup> *Ibid.*, 25.

<sup>43</sup> *Ibid.*, 33-34.

<sup>44</sup> *Ibid.*, 33.

<sup>45</sup> *Ibid.*, 34.

<sup>46</sup> *Ibid.*, 28.

<sup>47</sup> *Ibid.*

<sup>48</sup> *Ibid.*, 30.

<sup>49</sup> *Ibid.*, 29.

<sup>50</sup> *Ibid.*, 37. The Congressional mandate mentioned is described in more detail elsewhere: “To maintain good order and discipline, Congress has even required by statute that the sleeping and latrine areas provided for ‘male’ recruits be physically separated from the sleeping and latrine areas provided for ‘female’ recruits during basic training and that access by drill sergeants and training personnel ‘after the end of the training day’ be limited to persons of the ‘same sex as the recruits’ to ensure ‘after-hours privacy for recruits during basic training.’” *Ibid.*, 29.

<sup>51</sup> *Ibid.*, 30-31.

<sup>52</sup> *Ibid.*, 37.

<sup>53</sup> *Ibid.*

<sup>54</sup> *Ibid.*, 29.

<sup>55</sup> *Ibid.*, 36.

<sup>56</sup> *Ibid.*

<sup>57</sup> *Ibid.*, 29, footnote 109.

<sup>58</sup> *Ibid.*, footnote 110; citing Alex Bedard, et al., “Punching Through Barriers: Female Cadets Integrated into Mandatory Boxing at West Point,” Association of the United States Army, November 16, 2017, accessed February 1, 2019, <https://www.ausa.org/articles/punching-through-barriers-female-cadets-boxing-west-point>.

<sup>59</sup> The DoD “Report and Recommendations” do not indicate what percentage of the service members already diagnosed with gender dysphoria are biologically male or biologically female. A significant majority of Service members are male (84% of the enlisted forces and 82% of officers, as of 2016. See: George M. Reynolds and Amanda Shendruk, “Demographics of the U.S. Military,” Council on Foreign Relations, April 24, 2018, accessed February 1, 2019, <https://www.cfr.org/article/demographics-us-military>). Therefore, we may assume that most transgender-identified Service members are biological males who identify as female, but that has not been documented. Although the existence of lower physical fitness standards for females is designed to facilitate participation in the military by biological females, no similar accommodation is offered – even under the Obama/Carter policy – to facilitate participation by biological females who identify as male. Theoretically, it could be possible to allow such

---

individuals to continue to meet female standards while identifying as male, but that would introduce new layers of inequity.

<sup>60</sup> Ibid., 30.

<sup>61</sup> Ibid., 31.

<sup>62</sup> Ibid., 37-38.

<sup>63</sup> Ibid., 35-36.

<sup>64</sup> Ibid., 41.

<sup>65</sup> Peter Sprigg, "Transgender Policy Could Cost Military Billions Over Ten Years," Family Research Council, July 2017, <https://www.frc.org/transgendermilitarycost>, 2.

<sup>66</sup> Mattis, 2.