COURT FILE NUMBER	1808-00144
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	MEDICINE HAT
APPLICANTS	P.T., D.T., F.R., K.R., P.H., M.T., J.V., A.S., R.M., UNIVERSAL EDUCATION INSTITUTE OF CANADA, HEADWAY SCHOOL SOCIETY OF ALBERTA, THE CANADIAN REFORMED SCHOOL SOCIETY OF CALGARY, GOIND MARG CHARITABLE TRUST FOUNDATION, CONGREGATION HOUSE OF JACOB-MIKVEH ISRAEL, KHALSA SCHOOL CALGARY EDUCATION FOUNDATION, CENTRAL ALBERTA CHRISTIAN HIGH SCHOOL SOCIETY, SADDLE LAKE INDIAN FULL GOSPEL MISSION, ST. MATTHEW EVANGELICAL LUTHERAN CHURCH OF STONY PLAIN, ALBERTA, CALVIN CHRISTIAN SCHOOL SOCIETY, CANADIAN REFORMED SCHOOL SOCIETY OF EDMONTON, COALDALE CANADIAN REFORMED SCHOOL SOCIETY, AIRDRIE KOINONIA CHRISTIAN SCHOOL SOCIETY, DESTINY CHRISTIAN SCHOOL SOCIETY, KOINONIA CHRISTIAN SCHOOL-RED DEER SOCIETY, COVENANT CANADIAN REFORMED SCHOOL SOCIETY, LACOMBE CHRISTIAN SCHOOL SOCIETY, PROVIDENCE CHRISTIAN SCHOOL SOCIETY, LIVING WATERS CHRISTIAN ACADEMY, NEWELL CHRISTIAN SCHOOL SOCIETY, SLAVE LAKE KOINONIA CHRISTIAN SCHOOL, PONOKA CHRISTIAN SCHOOL SOCIETY, YELLOWHEAD KOINONIA CHRISTIAN SCHOOL SOCIETY, THE RIMBEY CHRISTIAN SCHOOL SOCIETY, LIVING TRUTH CHRISTIAN SCHOOL SOCIETY, LIGHTHOUSE CHRISTIAN SCHOOL SOCIETY, PARENTS FOR CHOICE IN EDUCATION, AND ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL-WESTERN CANADA

Clerk's Stamp

JUDICIAL CENTRE OF MEDICINE HAT
FAX
JUN 12 2018
FILED
Clerk of the Court

FIAT:
Leave is hereby granted this — day of June, 2018 to file the within Affidavit notwithstanding the

J.C.Q.B.A

RESPONDENT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT OF MIRIAM GROSSMAN**
ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	**Justice Centre for Constitutional Freedoms** #253, 7620 Elbow Drive SW Calgary, AB, T2V 1K2 Attention: Jay Cameron Telephone: (403) 909-3404 Facsimile: (587) 352-3233

AFFIDAVIT OF MIRIAM GROSSMAN

Sworn on June 11, 2018

I, MIRIAM GROSSMAN, of the City of Airmont, in the State of New York, United States of America, SWEAR AND SAY THAT:

1. I received my medical degree from New York University in 1979 and am a Medical Doctor who is board certified in psychiatry and in the sub-specialty of child and adolescent psychiatry.

2. Attached hereto and marked as **Exhibit "A"**, to this, my Affidavit, is a copy of my *curriculum vitae*, which details my education, expertise, research and publications.

Purpose of this Affidavit

3. I swear this Affidavit in order to respond to the Affidavit of Dr. Kevin Alderson, sworn in this action, and to provide studies that will assist the Court in an interim/interlocutory injunction application.

4. As a medical doctor, I can attest to the fact that there are several scientifically founded fundamentals relating to biology, sex, sexuality and gender within the practice of medicine.

   They are as follows:

i. Sex (male or female) is an objective, discreet, fixed condition, established at conception.

ii. This is a fact confirmed by the study of hard science such as embryology, histology, genetics, reproductive biology, cell biology, and endocrinology. All normal eggs carry one X chromosome, all normal sperm carry one Y chromosome. When an egg and sperm unite, a new cell called a zygote is formed. Depending on whether the sperm carried an X or Y chromosome, the zygote carries either XX (female) or XY (male) chromosomes. The zygote replicates, each time producing another cell with the identical set of chromosomes, XX or XY.

iii. Each chromosome is made of DNA. DNA is a protein molecule that instructs cells what to do. In the zygote, the DNA instructs it to grow into a female or male embryo. Therefore there are distinct male and female blueprints created from the moment of conception.

iv. The Y chromosome is teeming with units of DNA that are unique to males.[i] When a Y chromosome is present, the embryo develops testes that at about eight weeks begin to secrete testosterone, the male hormone. Thus the entire growing organism begins to be masculinized at eight weeks after conception. This includes the brain. [ii]

v. When a Y chromosome is absent, the embryo does not develop testes that secrete testosterone. It therefore develops in the "default" female direction. Its brain is not exposed to the same level of testosterone as a male embryo.

vi. Each cell in the embryo (later called the fetus) carries the same chromosomes as the original zygote, that is, XX or XY. When a child is born, each of its cells carries either XX or XY chromosomes.[iii] <u>This is a permanent condition and cannot be changed by hormones or surgery.</u>

vii. Documented differences in behavior between male and females are seen in the first year of life, some even as early as the first day of life, too early for any socializing or social agendas to impact the child. [iv]

viii. Confirming the biologic truth of innate, permanent differences between male and female are books such as the bestsellers *The Male Brain* and *The Female Brain* by the prominent neuropsychiatrist Louann Brizendine MD. She explains that males and females have "a distinct biology.... there is no unisex brain".[v]

ix. Also relevant are comments made by another scientist, Dr. Larry Cahill from the University of California, Irvine's Center for the Neurobiology of Learning and Memory:

> "The striking quantity and diversity of sex-related influences on brain function indicate that the still widespread assumption that sex influences are negligible cannot be justified, and probably retards progress in our field." [vi]

x. A team of neuroscientists at the Isis Fund for Sex Differences Research states: "There has been a renewed emphasis on the direct actions of the X and Y chromosomes in bringing about sex differences. Cutting-edge discoveries are revolutionizing our concepts of what makes a male or female brain."[vii]

xi. All the above is true outside of a number of rare medical conditions called Disorders of Sexual Development (DSD), whose names and frequency of occurrence are listed below by the Intersex Society of North America, an advocacy group for "people born with an anatomy that someone decided is not standard for male or female"[viii]

Not XX and not XY	one in 1,666 births
Klinefelter (XXY)	one in 1,000 births
Androgen insensitivity syndrome	one in 13,000 births
Partial androgen insensitivity syndrome	one in 130,000 births
Classical congenital adrenal hyperplasia	one in 13,000 births
Late onset adrenal hyperplasia *(see note below)*[ix]	one in 66 individuals
Vaginal agenesis	one in 6,000 births
Ovotestes	one in 83,000 births
Idiopathic (no discernable medical cause)	one in 110,000 births
Iatrogenic (caused by medical treatment, for instance progestin administered to pregnant mother)	no estimate
5 alpha reductase deficiency	no estimate
Mixed gonadal dysgenesis	no estimate
Complete gonadal dysgenesis	one in 150,000 births

xii. The claim that sex is not binary or fixed is false for all but the individuals suffering from these and other rare medical conditions. The description of male/female as a "continuum", with many normal (that is, non-medical) variations between the endpoints, is based on ideology, not hard science.

xiii. The argument that intersex conditions are common is not based on scientific reasoning.[x] According to Leonard Sax MD of The Montgomery Center for Research in Child and Adolescent Development:

> The available data support the conclusion that human sexuality is a dichotomy, not a continuum. More than 99.98% of humans are either male or female.... The birth of an intersex child, far from being "a fairly common phenomenon," is a rare event, occurring in fewer than 2 out of every 10,000 births.

xiv. **A male cannot become a female, and a female cannot become a male.** As explained, each cell in the body carries either male or female DNA that impacts the functioning of the body (including the brain). While the body can be somewhat altered by exogenous (meaning, from outside the body, not natural) hormones and/or surgery, it is impossible to provide male or female organs, and it is impossible to change the basic inborn "wiring" of each cell. The assertions of Dr. Alderson that it is possible to transition between male and female, or variations thereof, has no scientific or medical basis.

xv. A person with XY chromosomes who is feminized by exogenous estrogen and surgery cannot menstruate, conceive a child, or breastfeed in a natural manner. For those events to occur requires ovaries, a uterus, and the hormones, breast tissue, and brain physiology of the postpartum period.

xvi. A person with XX hormones who is masculinized with exogenous testosterone and surgery cannot produce sperm because there are no testes or prostate gland.

xvii. The medical records of any transgender person who has been treated with hormones and/or surgery will be flagged for their entire lives to alert medical providers of that fact. The medical care of these individuals will be unique by necessity[xi]. For this reason, there are specific guidelines for the medical treatment of transgender individuals[xii]. If the person had indeed "become" or "transitioned" into a true biological male or female, this would not be necessary. While the appearance of a transgender individual may be very convincing, indeed he or she may appear more attractive than so-called "cis-gender" individuals, that does not mean the objective reality of their sex has been changed.

5. I have also been asked to provide my professional medical opinion on the following:

The Harmful Effects of Informing Children They Can or Should Transition

i. **It is harmful to expose children and adolescents not suffering from a DSD to the following views**: male/female differences have no biological basis but are due only to socialization; male/female is not a binary condition; the persistent rejection of one's biological sex is not a disorder but a healthy option; a male can become a female and a female can become a male.

ii. The reason it is harmful to expose children and young people to these ideas is because they are not true.

iii. It is likely that at Gay Straight Alliance (GSA) meetings, the worldview described above is presented as indisputable scientific fact. Certainly, the scientific facts regarding the binary nature of male and female, and its immutability at a chromosomal level, is unlikely to be taught by those persons who are actively facilitating a particular narrative at these clubs. This is unethical and threatens the psychological well-being of students.

iv. One of the tasks of childhood and adolescence is to develop a strong identity. Having a strong identity is a hallmark of psychological health. Identity confusion can cause distress and can impact relationships and daily functioning.

v. The idea that it is possible or advisable to attempt to "transition" promoted by activists blur and call into question the most essential aspect of identity - whether one is male or female. It is confusing and frightening for the vast majority of children, especially young children, to learn that people are not necessarily what they appear to be, that doctors sometimes remove a penis and give people medicine to grow a beard or breasts. This information is often overwhelming for an adult to absorb, let alone a child. Especially in the most vulnerable children - those who already have anxiety, learning disability, lower IQ, or lack of stability at home (to mention just a few possibilities) – the exposure to frightening, age-inappropriate information may lead to more symptomatology.

vi.

Gender Transitioning: The Harmful Psychological and Physical Effects on Children

vii. **In the vast majority of individuals, gender dysphoria resolves with time**. This is well documented in the American College of Pediatricians 2017 document, *Gender Dysphoria in Children*,[xiii] and elsewhere. Given the extreme, life-altering hormonal and surgical treatments involved in "transitioning" to the other sex, and the very serious (ie, infertility) and even life-threatening (ie pulmonary embolism, cancer) possible adverse consequences of these interventions, it is in the best interest of the gender dysphoric pre-pubertal child to assist them in aligning their self-perception with their anatomic sex. According to a recent BBC documentary, this was and still is[xiv] the clinical opinion of Dr. Kenneth Zucker, a foremost authority on, and researcher of, gender identity issues in children. Unfortunately, due to the objections and threats of those who disagree with Dr Zucker, the film has not been widely seen in Canada or the US.

Puberty Blockers: The Permanent Physical Harm to Children

viii. Many physicians and therapists from across the political spectrum are critical of affirming children as transgender and of the use of puberty blockers - powerful hormones that arrest the normal development of boys into fully developed men and of girls into fully developed women. Even a group such as the "left-leaning, open-minded, and pro-gay rights" group youthtranscriticalprofessionals.org questions the wisdom of interrupting normal development.

"Gender Dysphoria in Children" (The American College of Pediatricians-ACP)

ix. **While the APA's membership is very significantly larger than the ACP's, it would be incorrect to conclude the position of the APA regarding gender dysphoria is more valid or truthful than the ACP's**. First of all, it's wise to keep in mind the wisdom of Maimonides: *Truth does not become more true by virtue of the fact that the entire world agrees with it, nor less so even if the whole world disagrees with it.* Second, the pressure to be politically correct cannot be overestimated. There is an atmosphere of fear in the mental health community. All members of the APA do not necessarily agree with every policy statement of that organization, but opinions of dissenters are squelched. Few are willing to speak out publicly on controversial subjects, such as gender or abortion; many clinicians are intimidated into silence for fear of losing their positions, funding, etc. This is widely known and is well-documented in the book *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm*[xv], co-authored by ex-president of the APA Nick Cummings PhD, and Rogers Wright, also a distinguished leader in the field of mental health. Another ex-president of the APA, Jack Wiggins PhD. wrote, "...in mental health circles today misguided idealism and social sophistry guarantee that good science and practice will not go unpunished."[xvi] It is my professional opinion that the position of the ACP regarding gender dysphoria represents good science and practice.

Psychological Harm to Children Advised Not to Trust Their Parents and to Families

x. **It goes without saying that honesty and trust are crucial elements of a healthy parent-child relationship.** This is axiomatic. With few exceptions, children should be encouraged to share their feelings and experiences, including how they spend their day, with their parents or guardians, especially if they are experiencing confusion or distress about as vital an issue as sex or sexuality. (Older teens who are developing towards healthy independence may choose to share less of their inner lives with family members.)

xi. To encourage or even suggest to any young person, in particular children and pre-teens, that it's ok to keep their parents in the dark about something that impacts the child is unethical and affects the child and his family in a destructive manner. Quite simply, it erodes trust. In general, parents sense when their child is pre-occupied and keeping important information from them. When this is ongoing, it erodes the trust a parent has for the child[xvii]. This is likely to cause distress and worry in the parent and may impact their ability to parent effectively. When a child realizes the parent disapproves, it causes distress in the child, and the result is a cycle of loss of trust, conflict, distress, and distancing between parent and child – the opposite of a strong bond so necessary for the healthy development of a child. It is also a heavy psychological load for a child to keep an important secret from her parents. It is my professional opinion that participation in a GSA club, in which a child is exposed to people and ideas that may be at odds with everything she has learned, will for some kids represent a burdensome secret that exacts a toll on her and her family.

The notion that individuals lacking a high level of professional training in both child and adolescent development and mental health, and who have not performed a formal individual assessment providing specific, in depth knowledge of an individual child and his family, know better than parents what is best for their child, goes against everything I was taught in medical school, in my pediatric and psychiatry training, and in my fellowship training in child and adolescent psychiatry. It also contradicts my experience of nearly thirty years of psychiatric practice.

xii. I swear this affidavit to provide expert evidence for the purpose of an injunction hearing in the within action, and for no improper purpose.

SWORN BEFORE ME at the city of)
Airmont, in the State of New York, U.S.A,)
this 11 day of June, 2018.)
)

Valentin Arroyo

A Notary Public in and for the State of New York

Miriam Grossman

MIRIAM GROSSMAN

Subscribed and sworn to before me this 11 day of June, 2018

VALENTIN A ARROYO
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01AR6371101
Qualified in Rockland County
My Commission Expires February 20, 2022

Footnotes:

[i] Helen Skaletsky et al, "The male-specific region of the human Y chromosome is a mosaic of discrete sequence classes," Nature 423, no 6942 (2003): 825–38.

2 Differences in fetal hormone levels can sometimes be discerned as early as day 16 post-fertilization.
3 Aside from mature red cells which have no nucleus or chromosomes.
[iv] Jennifer Connellan, Simon Baron-Cohen, Sally Wheelwright, Anna Batki, and Jag Ahluwalia, "Sex differences in human neonatal social perception," Infant Behavior and Development 23 (2000): 113–18; Svetlana Lutchmaya and Simon Baron-Cohen, "Human Sex Differences in social and non-social looking preferences, at 12 months of age," Infant Behavior and Development 25 (2002): 319–25; Svetlana Lutchmaya, Simon Baron-Cohen, and Peter Raggatt, (2002) "Foetal testosterone and eye contact in 12-month-old human infants," Infant Behavior & Development 25 (2000): 327–35.
[v] Louann Brizendine, 2006 The Female Brain, Broadway Books
[vi] Larry Cahill, "Why Sex Matters for Neuroscience," Nature Reviews Neuroscience 7 (June 2006): 477–84.
[vii] Jill B. Becker et al, eds., Sex Differences in the Brain: From Genes to Behavior (Oxford University Press, 2006), xviii; see also Daniel D. Federman, "The Biology of Human Sex Differences," The New England Journal of Medicine 354 (2006): 1507–14.
[viii] http://www.isna.org/; http://www.isna.org/faq/frequency
[ix] This condition should not be included, as it is not uniformly accepted as a DSD (see endnote 4)
[x] http://www.leonardsax.com/how-common-is-intersex-a-response-to-anne-fausto-sterling/
[xi] For biological males to take female hormones, such as estrogen, or biological females to take a male hormone, such as testosterone, is not without considerable health risk, particularly at the doses suggested. Males taking female hormones are at high risk for blood clots, which may be fatal if lodged in the lungs. They are also at increased risk for breast cancer, coronary artery disease, cerebrovascular disease, gallstones, and high levels of the lactation hormone prolactin. Females taking male hormones are at high risk for erythrocytosis (having a higher than normal number of red blood cells). They are also at increased risk for severe liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension and breast or uterine cancer.

Furthermore, the use of puberty-blocking drugs in adolescents has been associated with incomplete mineralization of bone, meaning these children may be at future risk for osteoporosis. There is very little information on the use of these blockers on brain development, but the studies we do have show potential for cognitive impairment.
[xii] http://transhealth.ucsf.edu/protocols
[xiii] www.ACPeds.org
[xiv] https://www.youtube.com/watch?v=Xmbk33TM-kc
[xv] Wright and Cummings (2005) Destructive Trends in Mental Health: The Well-Intentioned Path to Harm, Routledge
[xvi] Op. cit.
[xvii] Kerr M1, Stattin H, Trost K.(1999) To know you is to trust you: parents' trust is rooted in child disclosure of information.*J Adolesc.* 1999 Dec;22(6):737-52.

This is Exhibit "A" Referred To in the Affidavit of Miriam Grossman, Sworn before me this 11th day of June, 2018

Valentin Arroyo, Notary public for the State of N.Y.

Curriculum Vitae

Contact Information

Name: **Miriam Grossman, M.D.**

Email: MiriamGrossmanMD@hotmail.com

Education

1970-1974	Undergraduate:	Bryn Mawr College, Bryn Mawr, Penna. B.A., *cum laude*
1975-1979	Medical School:	New York University, New York, NY
1979-1980	Internship:	PGY I, Pediatrics, Beth Israel Hospital, NYC
1985-1987	Residency:	PGY II and III, Adult Psychiatry North Shore University Hospital (Cornell University) Manhasset, New York
1987-1989	Fellowship:	Child and Adolescent Psychiatry North Shore University Hospital (Cornell University)
2014		Training in neurofeedback for PTSD and other Disorders, EEG Institute, Thousand Oaks, CA

Employment and Affiliations

2016 -Current	Attending Psychiatrist, Mid-Hudson Forensic Psychiatric Center
2013-2016	Private Practice, Suffern, New York
June 2014	volunteer, Salvation Army shelter for homeless Vets. Provided neurofeedback.
July 2012-November 2012	Outpatient Psychiatry, Pride of Judea Clinic, Douglaston, New York

February 09 - April 2011	Vista del Mar outpatient clinic. Los Angeles, CA.
1995- 2008	UCLA Student Psychological Services, Los Angeles, CA. Evaluation and psychopharmacological treatment of students Provided diagnostic and emergency evaluations of undergraduate and graduate students including international students and those at the law, medical, and dental schools. This represents a very complex and diverse population. Crisis intervention and hospitalization, medication management, multidisciplinary case management, teaching and presentations to interns, consultation to staff consisting of psychologists and social workers, consultation to other campus departments as needed. Consulted with the Office of Student Disabilities, and the UCLA School of Law.
2000-2005	Private psychiatric practice. Diagnostic and emergency evaluation of children, adolescents and adults. Crisis intervention, medication management and psychotherapy.
2000-2001	Psychiatrist, Vista del Mar outpatient clinic. Evaluation and medication management of children and adolescents
1994-1995	Psychiatrist, Inpatient Adolescent Unit, Talbia Mental Health Center, Jerusalem, Israel.
1991-1993	Consultant, Young Adolescent Program, Southwood Hospital, Chula Vista, CA., including inpatient privileges.
1991-1994	Staff Psychiatrist, Frontier Adolescent Day Treatment Center, Santee, CA
1989-1993	Private Practice with Psychiatric Centers at San Diego, CA. Provided general child, adolescent and adult psychiatry, both inpatient and outpatient, emergency and diagnostic evaluations, crisis intervention, medication management, case management, consultation to multidisciplinary staff.

1989-1992	Clinical Investigator, Feighner Research Institute, San Diego, CA.
1989–1994	Inpatient privileges at Alvarado Parkway Institute, San Diego, CA.
1987-1989	Psychiatric residency at Cornell University affiliated North Shore University Hospital, Manhasset, NY in child and adolescent psychiatry. Consultant to the emergency room and to the pediatric and adolescent medical floors. The center specialized in the treatment of abused children and their families, eating disorders, and suicidal adolescents.
1985-1987	Psychiatric residency at Cornell University affiliated North Shore University Hospital, Manhasset, NY in adult psychiatry. Consultant in the emergency room, admitted to the inpatient unit, and cared for hospitalized and clinic patients. Consulted to medical and surgical floors as well as ICU's. Diagnostic interviews, crisis intervention, medication management, ECT.
1974-1975	Research assistant for Peter Auld MD, Director, Neonatology Department, Cornell University Medical Center. Examined sleep and respiratory patterns of premature infants and how these patterns may be related to sudden infant death syndrome.
Summer 1971	EEG lab assistant (electroencephalography), Presbyterian University Hospital, Department of Neurology, Pittsburgh, Pennsylvania. Prepared patients for exam, applied electrodes to head, monitored patient during exam, studied basic principles of electrical activity of the brain, and assisted attending neurologist in library research.

Books:

The Wonder of Becoming You: How a Jewish Girl Grows Up (1988) Feldheim Publishers. Translated into Spanish, French, Hebrew, German and Portuguese and still in print.

Unprotected: A Campus Psychiatrist Reveals How Political Correctness in Her Profession Endangers Every Student (2006) Penguin Group. Translated into Slovak and still in print.

You're Teaching My Child WHAT? A Physician Exposes the Lies of Sex Education and How They Harm Your Child (2009) Regnery – translated into Chinese and Rumanian and still in print

The Black & White Puppy: A Story About the Biology of Love (2015) The Center for Medical Integrity in Intimacy Education. Has been translated into Spanish and still in print.

Media and lectures:

Since writing *Unprotected*, I have been on over 200 international radio, news, and television shows. I have lectured in 22 States and in Canada, South America, the Caribbean, Europe, the Middle East and the Far East. I have testified at three state legislatures and lectured at the British House of Lords, the Parliament of New South Wales, and the United Nations.

Teaching:

1997	UCLA Student Health Center: "Psychiatric Emergencies"
1993	Instructor, University of California at San Diego Medical School "Human Growth and Development"
1992-1993	Presented lecture series at Southwood Hospital, San Diego, CA Topics included Tourette Syndrome, sexual abuse of children, child and adolescent psychopharmacology

University Committees:

2006	Member, UCLA Selection Committee-Psychological Services to review applications and interview applicants for psychiatry positions.
2005-2006	Member, UCLA Student Psychological Services Peer Review Committee. Attend weekly meeting in which difficult and complex cases are reviewed and treatment recommendations made.
1995	Member, system-wide committee of the University of California charged with developing practices for the documentation and accommodation of students with ADD/ADHD

Awards

2003	UCLA Physician's Performance-Based Augmentation Award (PPBA)
2000	UCLA PPBA award
1999	UCLA PPBA award
1974	Jane V. Myers Scholarship

Licensure

1980	Diplomat, National Board of Medical Examiners
1989	California License
1991	Diplomat, American Board of Psychiatry and Neurology
1993	Diplomat, Specialty of Child and Adolescent Psychiatry
2012	New York License