

**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF ILLINOIS**

STUDENTS AND PARENTS FOR )  
PRIVACY, a voluntary unincorporated )  
association; C.A., a minor, by and through her )  
parent and guardian, N.A.; A.M., a minor, by )  
and through her parents and guardians, S.M. )  
and R.M.; N.G., a minor, by and through her )  
parent and guardian, R.G.; A.V., a minor, by )  
and through her parents and guardians, T.V. )  
and A.T.V.; and B.W., a minor, by and )  
through his parents and guardians, D.W. and )  
V.W., )

No. 1:16 CV 4945  
  
The Hon. Jeffrey T. Gilbert,  
*Magistrate Judge*

Plaintiffs, )

v. )

UNITED STATES DEPARTMENT OF )  
EDUCATION; JOHN B. KING, JR., in his )  
official capacity as United States Secretary of )  
Education; UNITED STATES )  
DEPARTMENT OF JUSTICE; LORETTA E. )  
LYNCH, in her official capacity as United )  
States Attorney General; and SCHOOL )  
DIRECTORS OF TOWNSHIP HIGH )  
SCHOOL DISTRICT 211, COUNTY OF )  
COOK AND STATE OF ILLINOIS, )

Defendants, and )

STUDENTS A, B, and C, by and through )  
their parents and legal guardians Parents A, B, )  
and C, and the ILLINOIS SAFE SCHOOLS )  
ALLIANCE, )

Intervenor-Defendants. )

**INTERVENOR-DEFENDANTS' BRIEF IN RESPONSE TO PLAINTIFFS'  
MOTION FOR PRELIMINARY INJUNCTION**

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Transgender girls are girls, and transgender boys are boys. Plaintiffs' request for the extraordinary remedy of a preliminary injunction is premised on the false notion that "sex" is limited to a person's sex assigned at birth. Plaintiffs do not even attempt to provide scientific evidence to support their theory, which is unsurprising given that it is now firmly established that gender identity, not sex assigned at birth, is determinative of sex when those factors are not congruent. More importantly, Plaintiffs' cramped reading of the term "sex" ignores nearly thirty years of precedent recognizing that "sex" under federal law means much more than chromosomal makeup or anatomy and encompasses other aspects of a person's sex, including gender identity and transgender status. These errors are fatal to Plaintiffs' claim that transgender students' use of facilities that correspond with their gender identities amounts to "cross-sex" use. The policies to which Plaintiffs object do not authorize "cross-sex" use of facilities, and the mere presence of transgender students in school facilities does not constitute severe or pervasive harassment or violate constitutional guarantees of privacy. Plaintiffs' motion should be denied.

## **I. BACKGROUND**

### **A. Interests of the Intervenor-Defendants.**

The Intervenor-Defendants are three transgender students in District 211 ("the District") as well as the Illinois Safe Schools Alliance ("the Alliance"). Student A, a transgender girl, is the subject of a December 2015 agreement between the District and the Department of Education's Office of Civil Rights (OCR) permitting Student A to use the girls' locker rooms at William Fremd High School ("the Agreement"). *See* Dkt. 21-3. The Agreement requires the District to "install[ ] and maintain[ ] sufficient privacy curtains (private changing stations) within the girls' locker rooms." *Id.* at 2. Student A has been using the girls' restrooms since the fall of 2013 and began changing in one of the private changing areas in March 2016. Dkt. 32-1, ¶¶ 7, 18. Students

B and C are transgender boys who will soon attend District high schools and wish to use boys' restrooms and locker rooms at their respective schools. Dkt. 32-2, ¶ 19; Dkt. 32-3, ¶ 10. The Alliance is an organization that supports lesbian, gay, bisexual, and transgender Illinois students through advocacy and training, including in the District following its Agreement with OCR. Dkt. 32-4, ¶¶ 2–15.

**B. Gender Identity, Not Sex Assigned at Birth, Determines One's Sex.**

Contrary to Plaintiffs' repeated assertions that one's sex is limited to the sex assigned at birth, they are simply wrong on the facts. Without citing a single factual or scientific basis for their claim, Plaintiffs assert that Student A has an "objective biological status as a male," PI Mot. 1 n.1, based solely on the fact that Student A was assigned the sex male at birth. *See also* Ex. 1 at 3 (facts on which Plaintiffs rely limited to that Student A was "designated male at birth" or "born male"<sup>1</sup>); Ex. 2 at 2 (Plaintiffs admit they have not reviewed Student A's medical records or conducted medical examination of her). But the sex of a transgender student is determined by his or her gender identity. Ex. 3, ¶ 22. Research and the medical standards of care applicable to transgender students confirm that the sex of transgender students is determined by their gender identity, and that there is a biological basis showing that Plaintiffs have their "biological facts" wrong.

Transgender individuals have gender identities that differ from the sex they were assigned at birth. *Id.* ¶¶ 10–11. Assignments at birth are not definitive; in some cases they conflict with an individual's gender identity—a sense, internal to each and every human, of oneself as male, female, or something else. *Id.* ¶ 12. In addition, gender dysphoria—the medical diagnosis for the incongruence and accompanying distress when an individual's gender identity

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<sup>1</sup> Plaintiffs do not provide any factual basis for the conclusory statements attributed to the District that Student A is "biologically male"—statements that presumably also rest on the fact that Student A was assigned the sex male at birth.

differs from their birth-assigned sex—demonstrates that transgender status is grounded in medical research and clinical practice. *Id.* ¶ 15. The sole medically supported determinant of sex for individuals with gender dysphoria is gender identity. *Id.* ¶ 22. “Treatments” for gender dysphoria attempted in the past—which sought to force alignment of an individual’s gender identity and birth-assigned sex—were destructive failures. *Id.* ¶¶ 17–18. The now firmly established medical standard of care for treating gender dysphoria involves alleviating distress through supporting outward expressions of a person’s gender identity and bringing the body, gender expression, and gender presentation into alignment with gender identity to the extent that is medically appropriate. *Id.* ¶ 18.

In addition, contrary to Plaintiffs’ assertions, medical research from the endocrine, neuroanatomical, and genetic disciplines indicates that a person’s gender identity is firmly rooted in biology. *Id.* ¶ 14. For example, research shows transgender individuals possess a genetic factor that does not exist in cisgender persons; other studies have shown that persons with gender dysphoria have structural and connectivity differences in their brains as compared to other persons of their birth-assigned sex. *Id.* Even if gender identity were not grounded in biology, it would be determinative of a person’s sex where there is not complete alignment among a person’s sex-related characteristics. *Id.* ¶ 21.

Plaintiffs gloss over this research and the prevailing medical standards, but these facts disprove the central premise behind Plaintiffs’ theory that Student A is male and, thus, that Student A’s presence in the girls’ locker rooms threatens other girls’ privacy because there is “a biological male present.” PI Mot. 5, 13. Modern science confirms that Student A is a girl, so her presence in girls’ facilities is no more remarkable than any other girl’s, and it does not create a “cross-sex” situation or threaten anyone.



## II. PLAINTIFFS ARE NOT ENTITLED TO A PRELIMINARY INJUNCTION.

Granting a preliminary injunction “is an exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it.” *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of U.S. of Am., Inc.*, 549 F.3d 1079, 1085 (7th Cir. 2008). Plaintiffs have not even come close to satisfying the demanding standards for this “extraordinary and drastic remedy,” which “should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion.” *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). Plaintiffs fall short of their burden, as they cannot demonstrate “that they are likely to succeed on the merits of their claims,” “that the harm they would suffer without the injunction is greater than the harm that preliminary relief would inflict on the defendants,” or “that the injunction is in the public interest.” *Michigan v. U.S. Army Corps of Eng’rs*, 667 F.3d 765, 769 (7th Cir. 2011).

### A. Plaintiffs Are Unlikely To Succeed on the Merits of Their Claims, All Which Rest on a Factually and Legally Incorrect Definition of the Term “Sex.”

Plaintiffs’ claims are all premised upon a scientifically erroneous and legally outdated notion of what “sex” means under federal law. Each claim relies on Plaintiffs’ insistence that “sex” means only “biological male and female,” which Plaintiffs define narrowly and incorrectly as sex assigned at birth. PI Mot. at 6–7. It is on that theory that Plaintiffs maintain that the challenged Agreement between the District and OCR allows “cross-sex restroom and locker room use,” which they assert violates Plaintiffs’ privacy. *Id.* at 15–16. Plaintiffs’ Title IX claim similarly asserts that Defendants have harassed them “based on sex” because they have “open[ed] restrooms and locker rooms to students of the opposite biological sex.” *Id.* at 20–21. Plaintiffs’ APA claim—the final claim they discuss in their motion—is likewise based on this definition. *E.g., id.* at 5 (basing APA claim on assertion that “sex” in Title IX “means biological male and female”). As demonstrated above, this narrow and inaccurate view of sex is factually

and legally incorrect. It is also legally incorrect for the reasons explained below. Consequently, transgender students' use of facilities that correspond with their gender identities does not amount to "cross-sex restroom and locker room use," but rather, ordinary use by students of the sex for which the facilities are designated. Plaintiffs have no factual or legal basis for asserting that "cross-sex" use occurs, let alone use that could constitute severe or pervasive harassment or violate constitutional guarantees of privacy.

**1. The term "sex" under federal law includes gender identity and transgender status.**

Plaintiffs fail to account for two independent reasons why the term "sex" under federal law applies to transgender individuals. First, as a purely textual matter, the term "sex" plainly encompasses transgender status, because transgender people by definition are individuals who identify with a sex different from the sex assigned to them at birth. In other words, it is impossible to take into account a person's transgender status without taking into account their sex. *See Fabian v. Hosp. of Cent. Conn.*, No. 3:12-cv-1154, 2016 WL 1089178, at \*12 (D. Conn. Mar. 18, 2016) (a person's transgender status is incontrovertibly based on sex itself—*i.e.*, "the property or characteristic (or group of properties or characteristics) by which individuals may be so distinguished"); *Schroer v. Billington*, 577 F. Supp. 2d 293, 308 (D.D.C. 2008) (discrimination against transgender woman because of her gender transition "was *literally* discrimination 'because of . . . sex'"); *see also Price Waterhouse v. Hopkins*, 490 U.S. 228, 275 (1989) (O'Connor, J., concurring) (Title VII prohibits "the explicit consideration of . . . sex"). Several of Plaintiffs' own dictionary definitions of "sex" explicitly support this conclusion. *See* PI Mot. 6 n.11. Adverse actions affecting transgender people premised upon those properties and

characteristics that *make* them transgender quite literally “take gender into account,” *Price Waterhouse*, 490 U.S. at 239, and are thus unlawful.<sup>2</sup>

Second, the Supreme Court’s recognition in *Price Waterhouse* that employers may not discriminate based on sex stereotypes confirms that any definition of “sex” is not limited to a person’s sex assigned at birth, chromosomal make-up or anatomy, but also includes other aspects of a person’s sex, such as gender expression and an individual’s conformity (or lack of conformity) with social gender roles. In *Price Waterhouse*, the Supreme Court recognized that employers discriminate “because of sex” when they make adverse employment decisions based on sex-specific stereotypical beliefs, such as the notion that “a woman cannot be aggressive, or that she must not be.” *Id.* at 250. In holding that protection from discrimination “because of . . . sex” includes sex stereotyping, *Price Waterhouse* makes clear that the definition of “sex” extends beyond any “biological” differences among people. Rather, the “simple test” for discrimination because of sex is “treatment of a person in a manner which but for that person’s sex would be different.” *City of L.A., Dep’t of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978).

Every federal appellate court that has considered sex discrimination claims brought by transgender people post-*Price Waterhouse* has reaffirmed that laws prohibiting sex discrimination do not exclude transgender people from their protections. *Glenn v. Brumby*, 663 F.3d 1312, 1314 (11th Cir. 2011); *Smith v. City of Salem*, 378 F.3d 566, 570 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d

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<sup>2</sup> Numerous federal agencies charged with enforcing our nation’s sex discrimination laws have reached the same conclusion. *See, e.g., Macy v. Holder*, EEOC Doc. 0120120821, 2012 WL 1435995, at \*10 (EEOC Apr. 20, 2012) (“[I]f Complainant can prove that the reason that she did not get the job . . . is that the Director was willing to hire her when he thought she was a man, but was not willing to hire her once he found out that she was now a woman – she will have proven that the Director discriminated on the basis of sex.”); Nondiscrimination in Health Programs and Activities Rule, 81 Fed. Reg. 31,376 (May 18, 2016) (to be codified at 45 C.F.R. Part 95) (defining discrimination “on the basis of sex” to include gender identity discrimination).

1187, 1199–1203 (9th Cir. 2000); *see also Etsitty v. Utah Trans. Auth.*, 502 F.3d 1215, 1224 (10th Cir. 2007) (assuming without deciding that transgender employees may bring sex stereotyping claims under Title VII). Numerous other courts have allowed sex discrimination claims brought by transgender plaintiffs to proceed after *Price Waterhouse*.<sup>3</sup> As many courts have recognized, because “[a] person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes,” discrimination based on transgender status is a form of impermissible sex stereotyping. *Glenn*, 663 F.3d at 1316–18 (collecting cases). Plaintiffs fail to account for this foundational aspect of federal discrimination law, which invalidates the narrow conception of “sex” at the heart of their claims. *See Finkle v. Howard Cty.*, 12 F. Supp. 3d 780, 788 (D. Md. 2014) (“[A]ny discrimination against transsexuals (as transsexuals)—individuals who, by definition, do not conform to gender stereotypes—is proscribed by Title VII’s proscription of discrimination on the basis of sex as interpreted by *Price Waterhouse*”).

**2. *Ulane* has been overruled by subsequent Supreme Court decisions and is no longer good law.**

The primary case to which Plaintiffs repeatedly turn for their cramped understanding of “sex” is *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984). The *Ulane* plaintiff was a transgender pilot who sued her employer under Title VII for discriminatory termination. *Id.* at 1082. The court erroneously concluded “that Title VII does not protect transsexuals” despite that statute’s protection against discrimination “because of . . . sex,” based on its understanding that Congress did not intend for the statute to “apply to anything other than the traditional concept of sex.” *Id.* at 1085.

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<sup>3</sup> *See, e.g., Hughes v. William Beaumont Hosp.*, No. 13-cv-13806, 2014 WL 5511507 (E.D. Mich. Oct. 31, 2014); *Finkle v. Howard Cty.*, 12 F. Supp. 3d 780 (D. Md. 2014); *Schroer*, 577 F. Supp. 2d 293; *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d. 653 (S.D. Tex. 2008); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, No. 03-CV-0375E(SC), 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003).

*Ulane* rests on two fundamental legal errors that make it no longer good law. First, it limits the definition of “sex” to the “traditional” concept of being male or female. As already discussed, *Price Waterhouse* did away with such a limited notion of what “sex” means. Multiple courts of appeals and district courts have flatly contradicted Plaintiffs’ claim that “most courts agree with the Seventh Circuit’s *Ulane* decision.” PI Mot. at 17. Rather, “since the decision in *Price Waterhouse*, federal courts have recognized *with near-total uniformity*” that *Ulane*’s approach is no longer good law. *Glenn*, 663 F.3d at 1318 n.5 (emphasis added). *Ulane* “has been eviscerated by *Price Waterhouse*,” under which the federal antidiscrimination statutes’ “reference to ‘sex’ encompasses both the biological differences between men and women, and gender discrimination, that is, discrimination based on a failure to conform to stereotypical gender norms.” *Smith*, 378 F.3d at 573; *see also Schwenk*, 204 F.3d at 1201–02 (the “narrow[ ]” construction and “judicial approach” in *Ulane* “ha[ve] been overruled by the logic and language of *Price Waterhouse*”); *Fabian*, 2016 WL 1089178, at \*8–12 (“*Price Waterhouse* abrogates” *Ulane*); *Finkle*, 12 F. Supp. 3d at 788; *Radtko v. Misc. Drivers & Helpers Union*, 867 F. Supp. 2d 1023, 1032 (D. Minn. 2012) (rejecting “reliance on decades-old Title VII cases” including *Ulane*); *Schroer*, 577 F. Supp. 2d at 307; *Tronetti v. TLC HealthNet Lakeshore Hosp.*, No. 03-CV-0375E(SC), 2003 WL 22757935, at \*4 & n.15 (W.D.N.Y. Sept. 26, 2003). The sole post-*Price Waterhouse* case on which Plaintiffs rely for the assertion that *Ulane* is still followed, *Etsitty v. Utah Transit Authority*, 502 F.3d at 1224, is inconsistent with both the logic and the result in *Price Waterhouse*. Moreover, even the *Etsitty* decision assumed that transgender employees may bring sex discrimination claims under Title VII when they can present specific evidence of sex stereotyping, undercutting Plaintiffs’ theory that “sex” means only the fact of being male or female. *See Id.*

Notably, Plaintiffs fail even to mention *Price Waterhouse*, let alone attempt to reconcile *Ulane* with this subsequent binding authority or other legal developments in the more than 30 years since *Ulane* was decided.<sup>4</sup> More recently, “[t]he broader legal landscape has undergone significant changes” in the area of sex and gender discrimination, as well as other areas of human behavior that have long been subject to stereotyping and discrimination, such as sexual orientation. *E.g.*, *Christiansen v. Omnicom Grp., Inc.*, No. 15 Civ. 3440, 2016 WL 951581, at \*13 (S.D.N.Y. Mar. 9, 2016). As these developments illustrate, age-old errors of legal analysis need not tie the hands of modern courts with better evidence, better understanding, and decades more case law as guidance. *See Schroer v. Billington*, 424 F. Supp. 2d 203, 212 (D.D.C. 2006) (*Ulane*’s arguments “have lost their power after twenty years of changing jurisprudence on the nature and importance *vel non* of legislative history”).

*Ulane*’s second critical legal error was to rely on Title VII’s murky legislative history to support its holding that transgender individuals are not entitled to Title VII’s protections. The *Ulane* court inconsistently concluded both that there is a “total lack of legislative history supporting the sex amendment” to Title VII and that “Congress had a narrow view of sex in mind when it passed the Civil Rights Act.” 742 F.2d at 1085–86. Regardless of the truth or weight of these conflicting statements,<sup>5</sup> any reliance on congressional intent behind Title VII to determine its reach was squarely rejected in *Oncala v. Sundowner Offshore Services, Inc.*,

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<sup>4</sup> Plaintiffs also cite a 1982 decision, *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir. 1982), that mirrors *Ulane*’s mistaken textual analysis and erroneous parsing of legislative intent and has similarly been overruled by *Price Waterhouse*. *See Glenn*, 663 F.3d 1318 at n.5; *Smith*, 378 F.3d at 573.

<sup>5</sup> *Ulane*’s recounting of how Title VII’s sex provision came into being, for example, is the subject of academic dispute. The *Ulane* court stated that the “sex amendment was the gambit of a congressman seeking to scuttle adoption of the Civil Rights Act.” 742 F.2d at 1085. That account of the origins of the amendment, however, has been discredited by more recent scholarship. *See, e.g.*, Robert C. Bird, *More Than a Congressional Joke: A Fresh Look at the Legislative History of Sex Discrimination of the 1964 Civil Rights Act*, 3 Wm. & Mary J. Women & L. 137, 138, 143–44 (1997) (*Ulane*’s history of the amendment is wrong because the amendment was the “result of subtle political pressure from individuals, who for varying reasons, were serious about protecting the rights of women”); Jo Freeman, *How “Sex” Got Into Title VII: Persistent Opportunism as a Maker of Public Policy*, 9 Law & Ineq. 163 (1991).

523 U.S. 75, 79–80 (1998). In recognizing that Title VII protects against male-on-male sexual harassment, the Court observed that such behavior was “assuredly not the principal evil Congress was concerned with when it enacted Title VII. But statutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.” *Id.* at 79.

The Supreme Court has likewise rejected *Ulane*’s reliance on subsequent Congress’ rejection of amendments to Title VII that would have explicitly prohibited discrimination based on sexual orientation (but *not* transgender status) to support its claim that Congress took a narrow view of the concept of “sex.” *Ulane*, 742 F.2d at 1085–86. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) (“subsequent legislative history is . . . a particularly dangerous ground on which to rest an interpretation of a prior statute when it concerns . . . a proposal that does not become law”). Congressional inaction as to sexual orientation is irrelevant to what “sex” means in the statute—it has nothing to do with gender identity. And congressional failure to act could just as easily establish the opposite conclusion from that of the *Ulane* court—*i.e.*, Congress may have concluded that Title VII already covered sexual orientation and gender identity discrimination through its “because of . . . sex” language. *See Br. Amici Curiae of 128 Members of Congress, Christiansen v. Omnicom Grp., Inc.*, No. 16-748-cv, 2016 WL 3551468, at \*7 (2d Cir. June 28, 2016).

*Ulane* thus rests on two legal errors that have subsequently been exposed, as well as on the attitudes and knowledge of the very different era in which it was decided three decades ago. To be sure, the Seventh Circuit has not yet had the opportunity explicitly to overrule *Ulane*. But district courts in this circuit are not bound by Seventh Circuit precedent that has been overtaken by an “intervening change in the controlling authority.” *Cameo Convalescent Ctr., Inc.*

*v. Percy*, 800 F.2d 108, 110 (7th Cir. 1986); *see also Strautins v. Trustwave Holdings, Inc.*, 27 F. Supp. 3d 871, 879 (N.D. Ill. 2014) (“If existing circuit precedent cannot be reconciled with a subsequent ruling from the Supreme Court, then the latter governs.”); *Villasenor v. Indus. Wire & Cable, Inc.*, 929 F. Supp. 310, 313 (N.D. Ill. 1996) (“[W]e are bound by Seventh Circuit precedent unless and until a subsequent decision by that court or the Supreme Court undermines its holding.”). This Court is not bound by *Ulane*’s outmoded view of the definition of “sex,” which cannot be reconciled with *Price Waterhouse* or *Oncala*.

**3. Plaintiffs cannot succeed on the merits of their Title IX claim because the mere presence of a transgender person does not constitute severe or pervasive harassment.**

The foregoing discussion makes clear that Plaintiffs’ definition of “sex,” which is crucial to their Title IX claim, is wrong. Title IX prohibits sex-based harassment that is severe or pervasive. *See Hendrichsen v. Ball State Univ.*, 107 F. App’x 680, 684 (7th Cir. 2004). Plaintiffs go so far as to argue that Student A’s mere presence in the girls’ facilities amounts to such “harassment” because “[t]he biological differences between the sexes create a hostile environment when a male enters the girls’ facilities.” PI Mot. at 21. Plaintiffs provide zero scientific support for their cramped interpretation of a person’s “sex” and, as explained above, Student A’s presence in the girls’ facilities does not amount to a “male enter[ing] the girls’ facilities.” In any event, Plaintiffs’ “hostile environment” claim based on the mere presence of a transgender person in a sex-specific space is not cognizable under federal law. *See Cruzan v. Special Sch. Dist., No. 1*, 294 F.3d 981 (8th Cir. 2002). In *Cruzan*, the Eighth Circuit rejected the claim that allowing a transgender woman to use the women’s restroom created a hostile environment for a non-transgender woman in the absence of “any inappropriate conduct other than merely being present.” *Id.* at 984. Notably, the Eighth Circuit reached this conclusion despite having drawn an erroneous distinction between anatomical “sex” and behavioral



“gender” in *Sommers*. While *Sommers* is no longer good law in light of *Price Waterhouse*, the result in *Cruzan* illustrates that, regardless of one’s view of the proper determinant of sex, the mere presence of a transgender person, without more, does not constitute sex-based harassment, let alone harassment that is “severe or pervasive,” as required to prove a Title IX or Title VII violation. *Id.* Plaintiffs’ Title IX claim must fail.

**4. Plaintiffs have failed to show they will succeed on the merits of their constitutional privacy claim because private changing areas and showers are available for all female students.**

Even apart from the factual and legal shortcomings of their arguments about “sex,” Plaintiffs cannot show they will prevail on their privacy claim. That claim ignores provisions of the Agreement between the District and OCR that Plaintiffs are attacking, which establish a private changing area for “*any students* who wish to be assured of privacy while changing.” Dkt. 21-3 at 2 (emphasis added), as well as the District’s decision to make available private shower facilities for students who wish to use them. Dkt. 21-8 at 9. Specifically, the District agreed “to take steps to protect the privacy of its students by installing and maintaining sufficient privacy curtains (private changing stations) within the girls’ locker rooms.” *Id.* Student A herself said she would change within such private changing stations. *Id.*<sup>6</sup>

Plaintiffs argue that “Defendants could provide single-stall or other private accommodations to students who identify as the opposite sex.” PI Mot. 18. But the Agreement between OCR and the District does make “private accommodations” for *all* female students in the form of privacy curtains; accordingly, it mandates no “forced observations or inspections of the naked body” by anyone, let alone “a member of the opposite sex.” *Canedy v. Boardman*, 16

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<sup>6</sup> Additionally, Plaintiffs fail to explain why the mere presence of a transgender girl in the restroom, where there are assuredly individual, private stalls for each user, would implicate constitutional privacy interests. And while they assert that male student plaintiffs “typically use urinals without stalls,” Dkt. 23 at 21, they fail to explain why they are required to do so.

F.3d 183, 185 (7th Cir. 1994). Plaintiffs incorrectly contend that the Agreement “*require[s]* girls to undress, and attend to feminine hygiene needs, in locker rooms with a biological male present” and otherwise “*force[s]* children to shower, change clothing, or use the restroom in the presence of the opposite sex.” PI Mot. 13 (emphasis added). This is untrue. Plaintiffs’ historical ruminations about privacy—which egregiously conflate the mere presence of a transgender student in the locker room with “lawsuits against ‘Peeping Toms,’” sexting, and distribution of child pornography (*id.* at 13–14)—is premised upon the claim that students cannot avoid unclothed interaction with Student A. Under the Agreement, they can. Regardless, the premise of Plaintiffs’ claim is wrong; as already discussed, Student A’s presence in the girls’ restrooms or locker rooms is not that of an “opposite-sex student.” *Id.* at 15. She is a girl.

Furthermore, the cases Plaintiffs cite do not help them. For example, Plaintiffs cite *Norwood v. Dale Maintenance System, Inc.*, 590 F. Supp. 1410 (N.D. Ill. 1984), for the proposition “that the privacy violation arising from compelled risk of intimate exposure trumps Title VII’s bar on sex-based employment discrimination.” PI Mot. 15. But *Norwood* held no such thing. Both the plaintiff and the defendant in *Norwood* conceded that entry of a non-transgender female janitor into a men’s restroom would violate the privacy rights of any man who happened to be inside. Thus, the only question before the court was whether the bona fide occupational qualification exception to Title VII applied and whether the defendant provided reasonable alternatives for the plaintiff. *Norwood*, 590 F. Supp. 2d at 1417–23. Importantly, there is no indication that the facilities in *Norwood* offered privacy areas similar to those available at Fremd High School.

*Canedy* likewise involved facts and claims far afield from the case at bar. The plaintiff in *Canedy* was a male prisoner who did not want female guards strip-searching him “during a

shakedown” and requested “that shower curtains be installed” as well as temporary privacy coverings on cell windows. 16 F.3d at 184, 188. The Seventh Circuit reversed dismissal of the plaintiff’s complaint, which asserted a privacy interest in avoiding nude strip-searches from female guards that “particularly burden[ed] him because he is a Muslim.” *Id.* at 186 n.2. Students changing for gym class presents entirely different circumstances from forcible strip-searches of prisoners at a secure penal institution. And the privacy screens the *Canedy* plaintiff requested are *already in place* under the District’s agreement with OCR.

Plaintiffs cite *one case* for their sweeping assertion that courts “almost uniformly agre[e]” that “requiring students to use private facilities with opposite-sex students who identify as transgender violates privacy rights.” PI Mot. 16–17. *See Johnston v. Univ. of Pittsburgh*, 97 F. Supp. 3d 657 (W.D. Pa. 2015).<sup>7</sup> However, *Johnston* involved an equal protection claim brought by a transgender college student; it did not involve privacy claims of transgender or non-transgender students. Moreover, *Johnston* relied on the now-discredited reasoning in *Ulane, id.* at 675–78, and is flawed for the same reasons.

**B. Plaintiffs Cannot Satisfy the Other Requirements for a Preliminary Injunction.**

Plaintiffs’ failure to demonstrate a likelihood of success on the merits of their claims should end the Court’s consideration of their motion. Without such a showing, the Court “must deny the injunction.” *Girl Scouts of Manitou Council*, 549 F.3d at 1086. Plaintiffs also fail to meet the public interest or balance-of-hardships elements necessary to obtain a preliminary

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<sup>7</sup> In a footnote to their *Johnston* discussion, Plaintiffs mention three cases with a “see also” cite as if each had holdings similar to *Johnston*. They do not. *Jeldness v. Pearce*, 30 F.3d 1220 (9th Cir. 1994), did not involve transgender people at all; rather, the case was brought by female prisoners demanding equal opportunities within the prison system to those of men. *Id.* at 1222–23. The two other cases Plaintiffs cite also do not support their claims. In one, the plaintiff’s claim was dismissed on entirely procedural grounds without reaching the merits and without any reference to Title IX or privacy. *In re R.M.A.*, 477 S.W.3d 185, 186–87 (Mo. Ct. App. 2015). In the other, the court found that the plaintiff failed to establish standing but went on to state in dicta that she could not show that she was subject to sex discrimination; the case did not involve harassment or privacy claims. *Doe v. Clark Cty. Sch. Dist.*, No. 2:06-CV-1074-JCM, 2008 WL 4372872, at \*3–4 (D. Nev. Sept. 17, 2008).

injunction. Plaintiffs peg both these elements to the merits of their claims, which, as already shown, are unlikely to succeed. As a result, Plaintiffs fail to satisfy the public interest and balance-of-hardships elements as well.

Conversely, granting a preliminary injunction would cause immediate and irreparable injury to Intervenor-Defendants. Student A would face immediate harm if an injunction were to suspend the very agreement that she has fought for over the course of two years, during which she experienced substantial stress and anxiety. Dkt. 32-1, ¶¶ 6–17. Losing gender-appropriate restroom and locker room use would be traumatizing and embarrassing. *Id.* ¶ 20. Student A has already lost years of her high school experience—years she will experience “only once during [her] life”—and, if a preliminary injunction were to issue, she will irrevocably lose her senior year as well. *Doe v. Wood Cty. Bd. of Educ.*, 888 F. Supp. 2d 771, 778 (S.D. W. Va. 2012). Similarly, Students B and C will suffer significant discomfort, embarrassment and psychological harm if they are unable to use gender-appropriate restrooms when they enter District schools. Dkt. 32-2, ¶¶ 19–21; Dkt. 32-3, ¶¶ 10–12. And the Alliance’s work in assisting Student A will be undone and its advocacy efforts on behalf of transgender students damaged. Dkt. 32-4, ¶¶ 14–19.

Further, a preliminary injunction would damage the public interest, that is, the interest of non-parties. *See Abbott Labs. v. Mead Johnson & Co.*, 971 F.2d 6, 11–12 (7th Cir. 1992). The public has an interest in providing equal educational opportunity to all students. If a preliminary injunction were to issue, every transgender student in the District would suddenly lose the ability to use the gender-appropriate restroom, which could result in anxiety, learning difficulties, stigmatization, depression, and even suicidality for those students. Ex. 3, ¶¶ 23–29. An injunction would also create serious confusion and uncertainty for *all* families with students in the District over the status of the District’s Agreement with OCR just as a new school year

approaches—an Agreement finally reached this past December after years of negotiations and public hearings and debate.

### CONCLUSION

For the reasons stated above, the Intervenor-Defendants urge the Court to deny Plaintiffs' motion for a preliminary injunction.

Dated: July 8, 2016

John Knight  
ROGER BALDWIN FOUNDATION OF  
ACLU, INC.  
180 North Michigan Avenue  
Suite 2300  
Chicago, IL 60601  
Telephone: (312) 201-9740 ext. 335  
Facsimile: (312) 288-5225  
jknight@aclu-il.org

- and -

Ria Tabacco Mar\*  
American Civil Liberties Union  
FOUNDATION  
125 Broad St., 18th Floor  
New York, NY 10004  
Telephone: (212) 549-2627  
Facsimile: (212) 549-2650  
rmar@aclu.org

\* *Admitted pro hac vice*

Respectfully submitted,

/s/ Britt M. Miller  
Britt M. Miller  
Timothy S. Bishop  
Laura R. Hammargren  
Linda X. Shi  
MAYER BROWN LLP  
71 South Wacker Drive  
Chicago, IL 60606  
Telephone: (312) 782-0600  
Facsimile: (312) 701-7711  
bmiller@mayerbrown.com  
tbishop@mayerbrown.com  
lhammargren@mayerbrown.com  
lshi@mayerbrown.com

- and -

Catherine A. Bernard  
MAYER BROWN LLP  
1999 K Street, N.W.  
Washington, DC 20006-1101  
Telephone: (202) 263-3000  
Facsimile: (202) 263-3300  
cbernard@mayerbrown.com

*Counsel for Students A, B, and C, and the Illinois Safe Schools Alliance*

# **Exhibit 1**

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION**

**STUDENTS AND PARENTS FOR PRIVACY**, a voluntary unincorporated association; **C.A.**, a minor, by and through her parent and guardian, **N.A.**; **A.M.**, a minor, by and through her parents and guardians, **S.M.** and **R.M.**; **N.G.**, a minor, by and through her parent and guardian, **R.G.**; **A.V.**, a minor, by and through her parents and guardians, **T.V.** and **A.T.V.**; and **B.W.**, a minor, by and through his parents and guardians, **D.W.** and **V.W.**,

Plaintiffs,

vs.

**UNITED STATES DEPARTMENT OF EDUCATION**; **JOHN B. KING, JR.**, in his official capacity as United States Secretary of Education; **UNITED STATES DEPARTMENT OF JUSTICE**; **LORETTA E. LYNCH**, in her official capacity as United States Attorney General; and **SCHOOL DIRECTORS OF TOWNSHIP HIGH SCHOOL DISTRICT 211, COUNTY OF COOK AND STATE OF ILLINOIS**.

Defendants,

and

**STUDENTS A, B, and C**, by and through their parents and legal guardians **Parents A, B, and C**, and the **ILLINOIS SAFE SCHOOLS ALLIANCE**,

Intervenor-Defendants.

**Case No. 1:16-cv-04945**

**The Honorable Jeffrey T. Gilbert,  
Magistrate Judge**

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**INTERVENOR-DEFENDANTS'  
FIRST SET OF INTERROGATORIES TO PLAINTIFFS  
AND PLAINTIFFS' RESPONSES THERETO**

Plaintiffs respond to Intervenor-Defendants' First Set of Interrogatories as follows:

**INTERROGATORIES**

**Interrogatory No. 1:** State all facts upon which YOU base any denial of Request for Admission Nos. 1 and 2 contained in Intervenor-Defendants' First Set of Requests for Admission to Plaintiffs, dated June 27, 2016, and identify all persons who have information and/or knowledge regarding those facts.

**RESPONSE:** Object. Plaintiffs hereby incorporate their objections to Requests for Admission Nos. 1 and 2. Plaintiffs further object that Interrogatory No. 1 is burdensome, oppressive, and overbroad, seeking the identification of "all" persons who have information regarding Student A's biological sex. In addition, the identities of many, if not all, of those persons are already known by the proponents of the interrogatory, and they are in a better position to know the identities of those persons than are the Plaintiffs. Subject to these objections and without waiving them, all three defendants have stated that Student A is biologically male. *See Pls.' Mot. For Prelim. Inj.*, Ex. 8, Dkt. 21-10 (*Dep't of Educ.'s Letter of Findings*) (Defendant DOE stated that "Student A was born male..." Defendant School District was quoted as saying "permitting Student A to be present in the locker room would expose female students to being observed in a state of undress by a biologically male individual[,] "that it would be inappropriate for young female students to view a naked male in the locker room in a state of undress[,] and that allowing Student A to change his clothing in the girls' locker room "would expose female students as young as fifteen years of age to a biologically male body."); *Mem. Of Law in Supp. Of Mot. To Intervene as Defs. Of Students A, B, and C, by and through their Parents and Legal Guardians, and of the Ill. Safe Schs. All.*, Ex. 1 ¶ 4, Dkt. 32-1 (*Decl. of*



*Parent A*) (Student A's mother declared that Student A was "designated male at birth" but "came out" to his mother and father, as someone who perceives himself to be female, when he was in seventh grade). This is sufficient to establish that Student A is biologically male. In addition, all plaintiffs in this case are aware that Student A is biologically male for reasons that include knowledge of the Department of Education's Letter of Findings which stated that Student A is born male, and knowledge that their school district, which is the Defendant School District in this case, resisted allowing Student A into the girls' locker rooms for three years because Student A is biologically male. Persons who may have information about Student A's biological sex include, but are not limited to:

- Student A;
- Student A's parents;
- Other members of Student A's family, including any siblings;
- Students who have attended elementary, middle, or high school with Student A;
- Caregivers, including baby-sitters, who cared for Student A as a young child;
- Student A's pediatrician(s);
- Staff at the hospital where Student A was born, including the doctors and nurses who delivered Student A, performed Student A's initial pediatric exam, etc.;
- Student A's elementary school teachers;
- Persons employed or formerly employed by the Department of Education, Office for Civil Rights, including, but not limited to, Adele Rapport, Regional Director, and Catherine Lhamon, Assistant Secretary for Civil Rights;
- Persons employed or formerly employed by the Defendant School District, including, but not limited to, Daniel Cates, Superintendent, Nancy Robb, former Superintendent,

and others interviewed during the Department of Education's investigation of the Defendant District between December 2013 and January 2015.

Pursuant to Federal Rule of Civil Procedure 26(e), Plaintiffs reserve the right to supplement the above response as additional information becomes available in the further course of investigation and discovery.

DATED: 7/6/2016

THOMAS L. BREJCHA, IL 0288446  
PETER BREEN, IL 6271981  
JOCELYN FLOYD, IL 6303312  
**THOMAS MORE SOCIETY**  
19 S. La Salle Street, Suite 603  
Chicago, IL 60603  
(312) 782-1680  
(312) 782 -1887 Fax  
tbrejcha@thomasmoresociety.org  
pbreen@thomasmoresociety.org  
jfloyd@thomasmoresociety.org

By: /s/ Jeremy D. Tedesco  
JEREMY D. TEDESCO, AZ 023497\*  
JOSEPH E. LARUE, AZ 031348\*  
**ALLIANCE DEFENDING FREEDOM**  
15100 N. 90<sup>th</sup> Street  
Scottsdale, Arizona 85260  
(480) 444-0020  
(480) 444-0028 Fax  
jtedesco@adflegal.org  
jlarue@adflegal.org

J. MATTHEW SHARP, GA 607842\*  
**ALLIANCE DEFENDING FREEDOM**  
1000 Hurricane Shoals Road NE  
Suite D-1100  
Lawrenceville, Georgia 30043  
(770) 339-0774  
(770) 339-6744 Fax  
msharp@adflegal.org

*\*Admitted Pro Hac Vice*

*Attorneys for Plaintiffs*

**Gzj kdk'4**

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION**

**STUDENTS AND PARENTS FOR PRIVACY**, a voluntary unincorporated association; **C.A.**, a minor, by and through her parent and guardian, **N.A.**; **A.M.**, a minor, by and through her parents and guardians, **S.M.** and **R.M.**; **N.G.**, a minor, by and through her parent and guardian, **R.G.**; **A.V.**, a minor, by and through her parents and guardians, **T.V.** and **A.T.V.**; and **B.W.**, a minor, by and through his parents and guardians, **D.W.** and **V.W.**,

Plaintiffs,

vs.

**UNITED STATES DEPARTMENT OF EDUCATION**; **JOHN B. KING, JR.**, in his official capacity as United States Secretary of Education; **UNITED STATES DEPARTMENT OF JUSTICE**; **LORETTA E. LYNCH**, in her official capacity as United States Attorney General; and **SCHOOL DIRECTORS OF TOWNSHIP HIGH SCHOOL DISTRICT 211, COUNTY OF COOK AND STATE OF ILLINOIS**.

Defendants,

and

**STUDENTS A, B, and C**, by and through their parents and legal guardians **Parents A, B, and C**, and the **ILLINOIS SAFE SCHOOLS ALLIANCE**,

Intervenor-Defendants.

**Case No. 1:16-cv-04945**

**The Honorable Jeffrey T. Gilbert,  
Magistrate Judge**

---

**INTERVENOR-DEFENDANTS'  
FIRST SET OF REQUESTS FOR ADMISSION TO PLAINTIFFS  
AND PLAINTIFFS' RESPONSES THERETO**

Plaintiffs respond to Intervenor-Defendants' First Set of Requests for Admission as follows:

**REQUESTS FOR ADMISSION**

**Request No. 1:** Admit that YOU have no factual basis for disputing that STUDENT A is a girl.

**Answer:** Object. Request for Admission No. 1 is argumentative. It requires the adoption of an assumption, that gender identity and biological sex are the same thing, which they are not. Subject to this objection and without waiving it, Plaintiffs deny the statement contained in Request for Admission No. 1.

**Request No. 2:** Admit that YOU have not conducted any medical or psychological assessment or evaluation, or reviewed any medical or psychological records, of STUDENT A.

**Answer:** Object. Plaintiffs understand Request for Admission No. 2 to be interrelated to Request for Admission 1, and thus it is also argumentative. It requires the adoption of an assumption, that gender identity and biological sex are the same thing, which they are not. If Student A's biological sex was in dispute, his medical records would be relevant. But since the undisputed facts demonstrate that Student A is biologically male, there is no need to evaluate Student A's medical records or conduct a medical exam of Student A. Nonetheless, to the extent Intervenor-Defendants dispute that Student A is biologically male, Plaintiffs reserve the right to conduct any and all necessary discovery to prove that he is a biological male, including evaluating Student A's medical records and conducting a medical exam. Further, Student A's psychological records are not relevant to his biological sex, only to his gender identity. Because it is undisputed that Student A perceives himself to be a female, there is also no need at this time to evaluate Student A's psychological records or conduct a psychological exam of Student A.

Nonetheless, to the extent Intervenor-Defendants assert that Student A's psychological records are relevant to determining his biological sex or his gender identity beyond his self-perception, Plaintiffs reserve the right to conduct any and all discovery related to his psychological records and conduct psychological exams necessary to respond to Intervenor-Defendants claims. The requests for admission are also premature, as discovery has not commenced in this case and, absent discovery, Plaintiffs have no access to conduct any medical or psychological assessment or evaluation of Student A, or to review any of Student A's medical or psychological records. Subject to these objections and without waiving them, Plaintiffs admit that to date Plaintiffs have not conducted any medical or psychological assessment or evaluation, or reviewed any medical or psychological records, of Student A.

Pursuant to Federal Rule of Civil Procedure 26(e), Plaintiffs reserve the right to supplement the above response as additional information becomes available in the further course of investigation and discovery.

DATED: 7/6/2016

By: /s/ Jeremy D. Tedesco

THOMAS L. BREJCHA, IL 0288446  
PETER BREEN, IL 6271981  
JOCELYN FLOYD, IL 6303312  
**THOMAS MORE SOCIETY**  
19 S. La Salle Street, Suite 603  
Chicago, IL 60603  
(312) 782-1680  
(312) 782 -1887 Fax  
tbrejcha@thomasmoresociety.org  
pbreen@thomasmoresociety.org  
jfloyd@thomasmoresociety.org

JEREMY D. TEDESCO, AZ 023497\*  
JOSEPH E. LARUE, AZ 031348\*  
**ALLIANCE DEFENDING FREEDOM**  
15100 N. 90<sup>th</sup> Street  
Scottsdale, Arizona 85260  
(480) 444-0020  
(480) 444-0028 Fax  
jtedesco@adflegal.org  
jlarue@adflegal.org

J. MATTHEW SHARP, GA 607842\*  
**ALLIANCE DEFENDING FREEDOM**  
1000 Hurricane Shoals Road NE  
Suite D-1100  
Lawrenceville, Georgia 30043  
(770) 339-0774  
(770) 339-6744 Fax  
msharp@adflegal.org

*\*Admitted Pro Hac Vice*

*Attorneys for Plaintiffs*

# **Exhibit 3**



**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF ILLINOIS**

STUDENTS AND PARENTS FOR )  
PRIVACY, a voluntary unincorporated )  
association; C.A., a minor, by and through her )  
parent and guardian, N.A.; A.M., a minor, by )  
and through her parents and guardians, S.M. )  
and R.M.; N.G., a minor, by and through her )  
parent and guardian, R.G.; A.V., a minor, by )  
and through her parents and guardians, T.V. )  
and A.T.V.; and B.W., a minor, by and )  
through his parents and guardians, D.W. and )  
V.W., )

No. 1:16-cv-4945

The Hon. Jeffrey T. Gilbert,  
*Magistrate Judge*

Plaintiffs, )

v. )

UNITED STATES DEPARTMENT OF )  
EDUCATION; JOHN B. KING, JR., in his )  
official capacity as United States Secretary of )  
Education; UNITED STATES )  
DEPARTMENT OF JUSTICE; LORETTA E. )  
LYNCH, in her official capacity as United )  
States Attorney General; and SCHOOL )  
DIRECTORS OF TOWNSHIP HIGH )  
SCHOOL DISTRICT 211, COUNTY OF )  
COOK AND STATE OF ILLINOIS, )

Defendants, )

and )

STUDENTS A, B, and C, by and through )  
their parents and legal guardians Parents A, B, )  
and C, and the ILLINOIS SAFE SCHOOLS )  
ALLIANCE, )

Intervenor-Defendants. )

**EXPERT DECLARATION OF ROBERT GAROFALO, M.D., M.P.H.**

## PRELIMINARY STATEMENT

1. I have been retained by counsel for Students A, B, and C, by and through their parents and legal guardians, Parents A, B, and C, and the Illinois Safe Schools Alliance (together the “Intervenor-Defendants”) as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration.

2. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy of which is attached as Exhibit A to this declaration. I received my medical degree from New York University in 1992, and I received my masters in public health from Harvard University in 1999. I am a professor of pediatrics at Northwestern University Feinberg School of Medicine, the division head of adolescent medicine at the Ann & Robert H. Lurie Children’s Hospital, the co-director of the Gender & Sex Development clinical program, and the director of the Research Center for Gender, Sexuality and HIV Prevention at Ann & Robert H. Lurie Children’s Hospital. I have been licensed to practice medicine in Illinois since 2001. *See* Exhibit A.

3. I have extensive experience working with and researching issues surrounding lesbian, gay, bisexual, and transgender (LGBT) children and adolescents.

4. I am a member of the American Academy of Pediatrics, the Society for Adolescent Medicine, the American Public Health Association, the Gay and Lesbian Medical Association, the American Academy of HIV Medicine, the American Medical Association, and the World Professional Association for Transgender Health (“WPATH”), the leading association of medical and mental health professionals in the treatment of transgender individuals, as a member of WPATH’s Standards of Care Revision Committee. *See* Exhibit A.

5. As part of my practice, I stay familiar with the latest medical science and treatment protocols related to differences or disorders of sex development and gender dysphoria.

6. Over the course of my career I have cared for nearly 1,000 children and adolescents who identify as gender nonconforming or transgender. The clinical program in Gender & Sex Development currently has over 400 children and adolescents actively engaged in care. I am the Editor-in-Chief of the academic journal *Transgender Health*. I was a member of the Institute of Medicine Committee on The Health and Lesbian, Gay, Bisexual and Transgender People where my emphasis was on the care of transgender individuals. Finally, I have been the principal investigator on a number of NIH research grants related to transgender health, including the first U.S.-based study examining the long-term outcomes of medical interventions for transgender children and adolescents.

7. In preparing this declaration, I reviewed the materials listed in the attached Bibliography (Exhibit B). I may rely on those documents, in addition to the documents specifically cited as supportive examples in particular sections of this declaration, as additional support for my opinions. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

8. In the past four years, I have testified as an expert at trial or deposition in at least one state court case, in Bridgeview, Illinois.

9. I am not being compensated for my time spent on this litigation.

## **MEANING OF TRANSGENDER AND GENDER IDENTITY**

10. A transgender individual is someone who has a gender identity that differs from the person's birth-assigned sex. The term "transsexual" refers to those transgender persons who have undergone, or plan to undergo, medical treatment in the form of hormone therapy or gender confirmation surgeries or both.

11. During gestation or at birth, individuals typically are classified as male or female, often based on observation of their external genitalia and/or chromosomal testing. This classification is the person's birth-assigned sex, but it may not be the same as the person's gender identity.

12. The term "gender identity" is a well-established concept in medicine, referring to one's sense of oneself as male or female or something else. All human beings develop this elemental internal view: the understanding of belonging to a particular gender. Research and clinical experience suggest that many children develop a strong sense of gender identity at a young age, although individuals vary in the age at which they come to understand and express their gender identity.

13. Although research regarding the precise determinant of gender identity is still ongoing, research indicates that the development of gender identity involves an interplay of a number of factors, including biology, environment, culture, and socialization.

14. Studies supporting that gender identity has a strong biological basis includes data derived from the endocrine, neuroanatomical, and genetic disciplines. For example, brain studies have shown that persons with gender dysphoria have structural and connectivity differences in their brains as compared to other persons of their birth-assigned sex. In addition, studies

comparing identical and fraternal twin pairs have demonstrated that a genetic factor exists in an individual having a transgender identity.

### **GENDER DYSPHORIA**

15. The medical diagnosis for the incongruence and accompanying distress when an individual's gender identity differs from the birth-assigned sex is gender dysphoria. Untreated gender dysphoria can result in significant clinical distress, debilitating depression, and often, suicidality.

16. The criteria for establishing a diagnosis of gender dysphoria in adolescents and adults are set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V):

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated sex characteristics).
2. A strong desire to rid of one's primary/and or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

17. In the past, when mental health and medical practitioners identified a disconnect between a person's gender identity and birth-assigned sex, treatment often focused on efforts to

bring the individual's gender identity into alignment with the birth-assigned sex. These practices were unsuccessful and incredibly harmful to the patient.

18. Professional health organizations, including the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, recommend against implementing attempts to change a child's gender identity in clinical care. Instead, the appropriate treatment for those with gender dysphoria must focus on alleviating distress through supporting outward expressions of the person's gender identity and bringing the body, gender expression, and gender presentation into alignment with that gender identity to the extent deemed medically appropriate based on assessments of individual patients by their medical and mental health providers.

#### **ASSIGNMENT OF SEX**

19. For many people, gender identity aligns with their birth-assigned sex, so assigning sex based on sex characteristics such as external genitalia or chromosomes is a proxy for assigning sex based on one's gender identity.

20. For transgender people, however, there is not complete alignment among sex-related characteristics.

21. Where a more careful consideration of sex assignment is needed, that assignment should be based on gender identity. Using chromosomes, hormones, internal reproductive organs, external genitalia, or secondary sex characteristics to override gender identity for purposes of classifying someone as male or female is not supported by current medical literature or clinical standards.

22. Specifically for individuals with gender dysphoria, gender identity is the only medically supported determinant of sex when sex assignment as male or female is necessary.

**HARMFUL EFFECTS OF EXCLUDING TRANSGENDER CHILDREN FROM SCHOOL FACILITIES ALIGNED WITH THEIR GENDER IDENTITY**

23. Gender health is defined as a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection.

24. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at significantly higher risk for developing psychosocial adversities later in life, including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, substance abuse, incarceration, posttraumatic stress, and suicide ideation and attempts.

25. Social transition is a critical medical treatment for individuals with gender dysphoria. It is important that the social transition occur in all aspects of the individual's life. For a transgender student to be considered female in one situation, but not in another, is inconsistent with medical practice and is detrimental to the health and well-being of the child.

26. Access to restrooms and locker rooms available to others is an undeniable necessity for transgender students. In most school settings, restrooms and locker rooms, unlike other settings at the school, categorize people according to gender. There are two, and only two, such categories: male and female. To deny a transgender girl admission to such a facility, or to insist that she use a separate facility, communicates that such a person is "not female," negates a key aspect of a person's identity, interferes with the person's ability to consolidate identity, and undermines the social-transition process. From a developmental perspective, this type of inclusion allows young people the opportunity to learn and grow in a safe environment. We know that transgender youth who are not granted these protections become targets for rejection,

discrimination, and violence. And, most importantly, inclusion allows for all students to be healthy and protected members of their communities.

27. When transgender students are not permitted to use restrooms or locker rooms that match their gender identity, the necessity of using the restroom or locker room can become a source of anxiety, and makes it difficult for students to concentrate on learning and school activities. Transgender students often avoid drinking fluids during the day and hold their urine for the entire school day, making them prone to developing urinary tract infections, dehydration, and constipation. Further, attempts to negate a person's gender identity can pose health risks, including depression, post-traumatic stress disorder, hypertension, and self-harm.

28. School administrators and other adults play a critical role in whether a student will be stigmatized and ostracized by peers. Excluding a transgender student from restrooms and locker rooms singles out the student for potential stigmatization, victimization and bullying, which are predictors of current and future mental health and physical health problems. Stress and victimization at school is associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and suicidality later in life.

29. To minimize health risks associated with negation of gender identity, it is imperative that school environments create climates where youths are comfortable in expressing their identities. Schools that support LGBT students, and explicitly oppose bullying, create an environment in which all students feel safe and are able to learn. Research shows that LGBT children living in states and cities with more protective school climates are less likely to report to report suicidal thoughts than LGBT children living in states and cities with less protective climates.



Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 07-07, 2016.

By:   
Robert Gafofalo, M.D., M.P.H.

# **Exhibit A**

September 22, 2015

**ROBERT GAROFALO MD, MPH**

**DATE OF BIRTH:** NOVEMBER 3, 1965

**CITIZENSHIP:** U.S.A.

**HOME ADDRESS:**

840 W. Roscoe Apt 4W  
Chicago, IL 60657  
H: 773-960-2759

**WORK ADDRESS:**

155 E. Chicago Ave  
Box 161  
Chicago, IL 60613  
W: 773-388-8661  
F: 773-754-7618  
[rgarofalo@luriechildrens.org](mailto:rgarofalo@luriechildrens.org)

**EDUCATION**

1988 B.S. Interdisciplinary Major in Biological Psychology-Neuroscience  
Duke University; Durham, NC  
1992 M.D. New York University School of Medicine; New York, NY  
1999 M.P.H. Family and Community Health  
Harvard University School of Public Health; Boston, MA

**GRADUATE MEDICAL EDUCATION**

1992-95 Internship and Residency in Pediatrics,  
Children's Hospital of Philadelphia/University of Pennsylvania, Philadelphia, PA  
1995-97 Academic Pediatric/Dyson Advocacy Fellowship, Division of General Pediatrics,  
Children's Hospital/Harvard Medical School, Boston, MA  
2000-01 Adolescent Medicine Fellowship, Division of Adolescent/Young Adult Medicine  
Children's Hospital/Harvard Medical School, Boston, MA

**MEDICAL LICENSURE AND BOARD CERTIFICATION**

1995-01 Massachusetts Medical License  
1997-11 Board Certified in Pediatrics  
2002- Board Certified in Adolescent Medicine  
2001- Illinois Medical License

**FACULTY APPOINTMENTS**

1995-97 Clinical Fellow in Pediatrics  
Harvard Medical School, Boston, MA  
1997-01 Instructor in Pediatrics  
Harvard Medical School, Boston, MA  
2001-08 Assistant Professor in Pediatrics and Preventive Medicine  
Northwestern University's Feinberg School of Medicine, Chicago, IL  
2007- Visiting Senior Scientist  
The Fenway Institute, Boston MA  
2008-2014 Associate Professor in Pediatrics and Preventive Medicine  
Northwestern University's Feinberg School of Medicine, Chicago, IL  
2014- Professor in Pediatrics and Preventive Medicine  
Northwestern University's Feinberg School of Medicine, Chicago, IL

### **HOSPITAL/HEALTH CENTER STAFF APPOINTMENTS**

1995-97 Fellow in Medicine, Division of General Pediatrics  
Children's Hospital/Harvard Medical School. Boston, MA

1997-01 Assistant in Medicine/Attending Physician, Division of General Pediatrics  
Children's Hospital/Harvard Medical School. Boston, MA

1995-01 Attending Physician in Adolescent Medicine  
Justice Resource Institute (JRI)/Sidney Borum Jr. Community Health Center. Boston, MA

2000-01 Staff Physician, Department of Neonatology  
Beth Israel Deaconess Medical Center/Harvard Medical School. Boston, MA

2001-11 Attending Physician in Adolescent Medicine  
Howard Brown Health Center. Chicago, IL

2001- Attending Physician, Division of General Academic Pediatrics/Infectious Diseases  
Ann & Robert H. Lurie Children's Hospital/Northwestern University. Chicago, IL

### **HOSPITAL/HEALTH CENTER ADMINISTRATIVE APPOINTMENTS**

1997-01 Director of Adolescent Medicine. JRI/Sidney Borum Community Health Center. Boston, MA.

1998-01 Medical Director: HRSA/Ryan White Title IV funded Adolescent HIV Initiative  
JRI/Sidney Borum Community Health Center. Boston, MA.

2001- Director of Adolescent HIV Services.  
Children's Memorial Hospital/Howard Brown Health Center. Chicago, IL

- Provided clinical and programmatic leadership for the development of a unique "one stop shopping" multi-disciplinary program that currently care for >170 HIV+ youth ages 12-24. One of 16 national sites funded under HRSA Ryan White Title IV's Adolescent Initiative, the program brings together the strengths of academic medicine and community-based health offering adolescents the full range of clinical, outreach/prevention, and social support services in a seamless model of care. Engagement in federally-funded clinical and prevention research is an integral part of the care model.

2003-05 Director of Youth Services. Howard Brown Health Center. Chicago, IL

- Provided leadership the opening and development of the *Broadway Youth Center* – Chicago's first 5-6 day/week comprehensive youth drop-in space for at-risk youth (including the homeless and lesbian, gay, bisexual and transgender youth age 12-24). Services (at no charge) include: medical care, confidential family planning individual counseling, support groups, case management, housing assistance programs, HIV/STD testing and counseling, vocational and educational trainings, and basic needs services.

2006-11 Deputy Director/Director Department of Research. Howard Brown Health Center. Chicago, IL

- Responsible for the program direction and management of the Youth Services, Community Services, HIV/AIDS Prevention Programs, and Research Departments of this community-based health and social service center. Howard Brown Health Center's mission is to provide quality, culturally appropriate care to the lesbian, gay, bisexual and transgender community and the community around them.

2011- Director. Research Center of Excellence for Gender, Sexuality and HIV Prevention  
Ann & Robert H. Lurie Children's Hospital. Chicago, IL

- Responsible for the day-to-day oversight of a translational research unit with >25 full-time staff. The Center has been awarded several NIH and CDC-funded extramural HIV prevention research grants as well as programmatic grants from the City of Chicago devoted to HIV/STI testing and counseling and linkage-to-care services for newly diagnosed HIV+ youth. Most recently our Center was awarded seed monies from the Chicago-based Tawani Foundation to start one of the nation's first multi-disciplinary clinical and research programs for gender non-conforming children and adolescents.

2013- Division Head. Adolescent Medicine. Ann & Robert H. Lurie Children's Hospital. Chicago, IL

**OTHER EMPLOYMENT**

2011- Founder/Executive Director. Fred Says  
\*\*Fred Says is a registered 501c3 non-profit charity that raises money for HIV+ teens. The recipient of the funds to date has been Ann & Robert H. Lurie Children's Hospital of Chicago to support their adolescent HIV program. See [www.fredsays.org](http://www.fredsays.org)

**HONORS AND AWARDS**

1988 Magna Cum Laude. Duke University  
1992 Alpha Omega Alpha (AOA). New York University School of Medicine  
1992 AOA Achievement Award. New York University School of Medicine  
2000 Justice Resource Institute (JRI) Healthcare Employee of the Year  
2001 Beth Israel Deaconess Medical Center Community Service Award  
2005 Friend for Life Award. Howard Brown Health Center  
2009 Gay and Lesbian Medical Association Lifetime Achievement Award  
2011 City of Chicago LGBT Hall of Fame Inductee  
2012 Spirit of Hope Award. Chicago Department of Public Health

**PROFESSIONAL ORGANIZATION AND SCIENTIFIC ACTIVITY--MEMBERSHIP**

1992- American Academy of Pediatrics  
1996- Society for Adolescent Medicine  
1997-99 American Public Health Association  
1999- Gay and Lesbian Medical Association (Past President 2005-2007)  
2004-08 American Academy of HIV Medicine  
2006- American Medical Association  
2010- World Professional Association for Transgender Health

**PROFESSIONAL ACTIVITIES**

**PROFESSIONAL AND SCIENTIFIC ACTIVITY – LEADERSHIP POSITIONS AND PUBLIC SERVICE**

1996 Internship: Health Resources Services Administration/Bureau of Maternal Child Health. Rockville, MD  
1996-97 Health Policy Fellow: Senator Edward M. Kennedy. Washington, DC  
1999-00 Consultant: Governor's Commission on Gay and Lesbian Youth. Boston, MA  
1999-00 Consultant: Massachusetts Department of Education AIDS Advisory Panel. Boston, MA  
2000 Advisory Committee: National Pediatric & Family HIV Resource Center. "Making Meds Work For You: A Resource Guide For HIV+ Youth." Newark, NJ  
2000-03 Co-Director of Lesbian, Gay, Bisexual and Transgender Youth Special Interest Group Society for Adolescent Medicine; Blue Springs, MO  
2003- Board of Directors. Gay and Lesbian Medical Association San Francisco, CA  
2003-4 Advisory Board: Physicians for Reproductive Choice and Health/American Civil Liberties Union, Inc. "Minors' Access to Confidential Health Care in Illinois." New York, NY  
2005- Adolescent Research Advisory Committee NIH Pediatric AIDS Clinical Trials Group (PACTG); Washington D.C.  
2006 Consultant/Speaker. HRSA Ryan White Title IV: Caring for the HIV+ Transgender Youth Washington D.C.  
2006 Advisory Committee Member. Centers for Disease Control and Prevention (CDC) Behavioral Risk Surveillance System for Transgender Individuals; Atlanta, GA  
2007 Consultant. Centers for Disease Control and Prevention (CDC) Adolescent Committee: 2006 HIV Testing Guidelines; Atlanta, GA  
2007 Invited Speaker: Institute of Medicine/National Academies of Sciences

2008 Committee on Adolescent Health Care Services and Models of Care; Washington D.C.  
Steering Committee Member  
2008 National Methamphetamine Summit  
2008- Substance Abuse & Mental Health Services Administration (SAMHSA); Washington D.C.  
Project Advisory Committee (PAC)  
2009- American Medical Association/GLMA Physician Survey Project; Chicago, IL  
National Community Advisory Board. Human Rights Campaign. Healthcare Equality  
Index; Washington DC  
2010-11 Committee Member. National Academy of Sciences/Institute of Medicine Committee.  
LGBT Research Gaps and Opportunities; Washington DC  
2011 Expert Advisory Panel. The Joint Commission. Advancing Effective Communication,  
Cultural Competence, and Patient- and Family-Centered Care for LGBT Communities: A  
Field Guide; Oakbrook Terrace, IL  
2012 Consultant. Centers for Disease Control and Prevention Consultation on YMSM and HIV  
Surveillance; Atlanta, GA  
2012 Consultant. Centers for Disease Control and Prevention. Better Understanding HIV  
Prevention Research in MSM. Atlanta, GA  
2012 Consultant. Sexual Trafficking and Exploitation of Adolescents in the United States:  
Conceptual Framework and Policy Strategies. Radcliffe Institute. Cambridge, MA  
2012- Faculty. HRSA-sponsored National LGBT Health Education Center  
Fenway Institute. Boston, MA  
2012- Editorial Board. LGBT Health Journal. Mary Ann Liebert, Inc. Publishers  
2015- Editor- in-Chief, Transgender Health. Mary Ann Liebert, Inc. Publishers

**INSTITUTIONAL & COMMUNITY SERVICE**

1997-00 Co-coordinator of the HIV/AIDS Curriculum Development Committee  
Harvard Medical School. Boston, MA.  
1998-00 Government Affairs Committee. National AIDS Policy Center for Children Youth and  
Families. Washington, DC.  
2001- Physician Consultant. Teen Living Program for Homeless Youth  
Chicago, IL  
2001 Chair, Organizing Committee. Pediatric and Adolescent HIV: An International Perspective.  
National Security Education Program/Northwestern University (CME)  
Chicago, IL.  
2003-7 Education Committee. Gay and Lesbian Medical Association  
San Francisco, CA.  
2003- Professional Education Committee. Northwestern University Feinberg School of Medicine  
Master's in Public Health Program  
Chicago, IL  
2004 Co-Chair, Organizing Committee. Moving Forward Together  
Gay and Lesbian Medical Association 23<sup>rd</sup> Annual Conference. (CME)  
Palm Springs, CA  
2005 Co-Chair, Organizing Committee. Access, Diversity and Advocacy  
Gay and Lesbian Medical Association 24<sup>th</sup> Annual Conference. (CME)  
Montreal, Canada  
2005-07 President – Board of Directors. Gay and Lesbian Medical Association (GLMA)  
San Francisco, CA  
2006 Consultant. Bones Television Program; Twentieth Century Fox Television  
Los Angeles, CA  
2006 Co-Chair, Organizing Committee. Families and Science  
Gay and Lesbian Medical Association 24<sup>th</sup> Annual Conference. (CME)  
San Juan, PR  
2006 Course Director. Pediatric Pearls in Adolescent Medicine.  
Children's Memorial Hospital

- 2006-09 Rosemont, IL  
National Advisory Council for The Healthcare Equality Index  
Human Rights Campaign  
Washington D.C.
- 2008 Consultant –Serosorting as an HIV Prevention Strategy among MSM  
Centers for Disease Control and Prevention  
Atlanta, GA
- 2012 Community Advisory Board. Community Outreach Intervention Projects  
University of Illinois at Chicago  
Chicago, IL
- 2013- National Mental Health Advisory Board. Trevor Project  
Los Angeles, CA
- 2013 Board of Directors. National Advocates for Youth  
Washington DC

**TEACHING EXPERIENCE – MEDICAL STUDENT AND RESIDENT**

- 1996-98 Preceptor for first and second year medical students in the Patient-Doctor I and II courses  
Harvard Medical School, Boston, MA.
- 1997-00 Preceptor for resident education in an urgent care ambulatory clinic  
Children’s Hospital, Boston, MA.
- 1998-00 Longitudinal preceptor for third year medical students in a primary care setting  
University of Massachusetts Medical School. Worcester, MA.
- 1999-01 Longitudinal preceptor for third/fourth year medical students in primary care setting  
Harvard Medical School, Boston, MA.
- 2000-01 Teaching conferences for resident education in adolescent medicine  
Children’s Hospital/Harvard Medical School, Boston, MA.
- 2001- Teaching conferences for resident and medical student education in adolescent medicine  
Children’s Memorial Hospital/Northwestern University, Chicago, IL.
- 2001- Preceptor for resident and medical student education in adolescent medicine  
Children’s Memorial Hospital/Northwestern University, Chicago, IL.
- 2004 Visiting Professor (March 15-20<sup>th</sup>). Department of Pediatrics  
University of Hawaii/John A. Burns School of Medicine. Honolulu, HA
- 2006 Visiting Professor (Nov 1<sup>st</sup>-3<sup>rd</sup>). Department of Pediatrics  
Yale University School of Medicine. New Haven, CT
- 2007 Visiting Faculty. School of Public Health  
University of Pittsburgh School of Medicine. Pittsburgh, PA
- 2008- Mentorship: Junior Faculty and Fellows  
Children’s Hospital of Philadelphia and Northwestern University
- 2010 Visiting Professorship (Sept. 12<sup>th</sup>-13<sup>th</sup>). Department of Pediatrics  
Indiana University School of Medicine. Indianapolis, IN

**TEACHING EXPERIENCE (WORKSHOPS): CME AND OTHER INVITED SYMPOSIA—(SELECTED)**

- Mar. 1997 Workshop: It’s not what you are, but how you feel: health care issues for transgender youth.  
Society for Adolescent Medicine Annual Meeting.  
Los Angeles, CA. (CME)
- Aug. 1999 Workshop: Suicide is ravaging LGBTQ youth – fact or fiction? National Gay and Lesbian  
Medical Association Conference.  
San Diego, CA. (CME)
- Jun. 1999 Workshop: Comprehensive approach to addressing GLB youth risk behavior in clinical  
settings. Governor’s Commission on Gay and Lesbian Youth Annual Conference.  
Boston, MA.
- Dec. 1999 Workshop: Addressing sexuality in clinical practice. Harvard Medical School Multicultural  
Medicine: A Clinical Course for Primary Care and Mental Health Practitioners.  
Boston, MA. (CME)

- Jan. 2001 Workshop: Youth violence and suicide. Massachusetts Medical Society Conference - Hearing All Voices: Better Health Care for the GLBT Community. Waltham, MA. (CME)
- May 2001 Workshop: Making your office welcoming to gay, lesbian, bisexual, and transgender (GLBT) youth. Postgraduate Course in Adolescent Medicine: Harvard Medical School/Children's Hospital. Boston, MA. (CME)
- Jun. 2001 Workshop: Outreach and enhancing healthcare for GLBT youth/young adults. New England AIDS Education & Training Center: Adolescents and HIV Update. Milford, MA. (CME)
- Aug. 2001 Workshop: The invisible minority: Identifying and addressing the health needs of clients with alternative sexual orientation. National Association of Community Health Centers. Denver, CO (CME)
- May 2002 Workshop: Remembering the adolescent in adolescent HIV. Speaker: 5<sup>th</sup> Annual Conference on Homeless Youth. Chicago, IL. (CME)
- Mar. 2003 Workshop: Teaching gay and lesbian health issues to students and residents. Society for Adolescent Medicine Annual Meeting. Seattle, WA. (CME)
- Mar. 2003 Workshop: Measuring sexual orientation in survey research – understanding research method with LGBT youth. Society for Adolescent Medicine Annual Meeting. Seattle, WA (CME)
- April 2003 Workshop: Everything you wanted to know about adolescent gynecology, but were afraid to ask. Children's Memorial Hospital Pediatric Pearls Conference. Oakbrook, IL(CME)
- April 2003 Workshop: Adolescent health and the law. Illinois Caucus of Adolescent Health. Chicago, IL. (CME)
- Mar. 2004 Talking to teens about sex and sexuality  
Workshop: University of Hawaii/John A. Burns School of Medicine  
Honolulu, HA
- June 2004 Providing culturally competent care to the lesbian, gay, bisexual, and transgender adolescent.  
Northwestern University-Sponsored PriMed Conference. (CME)  
Rosemont, IL
- June 2004 Adolescent health and sexually transmitted diseases: A case-based discussion.  
Northwestern University-sponsored PriMed Conference. (CME)  
Rosemont, IL
- June 2006 Adolescent Medicine: Club Drugs.  
Northwestern University-sponsored PriMed Conference. (CME)  
Rosemont, IL
- Mar. 2006 STD 101: A Primer for Adolescent Medicine Providers.  
Children's Memorial Hospital Pediatric Pearls Conference: Adolescent Medicine  
Rosemont, IL (CME)
- Oct. 2007 Designing HIV prevention programs for transgender youth  
AIDS Foundation of Chicago: Meeting Today's HIV Prevention Challenges Conference  
Chicago, IL
- Oct. 2007 Caring for LGBT youth within the clinical setting.  
Children's Memorial Hospital Pediatric Pearl Conference: Primary Care  
Rosemont, IL(CME)
- Oct 2008 Creating a welcoming environment for LGBT patients  
GLMA Annual Conference  
Seattle, WA (CME)
- Dec 2010 Gender atypical behaviors and sexuality  
American Academy of Pediatrics



- DB:PREP- An Intensive Review and Update of Developmental-Behavioral Pediatrics  
Chicago, IL (CME)
- Oct 2012 Clinical models of care for transgender youth  
Indiana University Adolescent CME Course (CME)  
Indianapolis, IN (CME)
- Nov 2012 The high-risk adolescent  
American Academy of Pediatrics  
DB:PREP- An Intensive Review and Update of Developmental-Behavioral Pediatrics  
Phoenix, AZ (CME)
- Nov 2012 Gender atypical behaviors and sexuality  
American Academy of Pediatrics  
DB:PREP- An Intensive Review and Update of Developmental-Behavioral Pediatrics  
Phoenix, AZ (CME)
- Nov 2012 Substance use and the adolescent patient  
American Academy of Pediatrics  
DB:PREP- An Intensive Review and Update of Developmental-Behavioral Pediatrics  
Phoenix, AZ (CME)

**TRAINEES**

- 2004-08 Faculty Mentor for Northwestern MPH students as part of their summer field experience in community-based health and research.
- 2007-08 Brian Mustanski PhD. As Dr. Mustanski was completing his postdoc fellowship training and was junior faculty at the University of Illinois at Chicago, I served as the official mentor of his American Foundation of Suicide Prevention award which funded the development of Project Q2 one of the first longitudinal studies to examine the health and development of LGBT youth. Dr. Mustanski and I continue to collaborate and have co-authored more than 10 peer-reviewed manuscripts. We are also Co-PI's on NIDA-funded RO1 (RO1DA025548) He has gone on to have an extremely successful career as an academic researcher at Northwestern in the field of YMSM and HIV prevention.
- 2007-09 Najah Musacchio MD. I was Dr. Musacchio's primary clinical and research mentor during her times as fellow in the Division of General Academic Pediatrics at Northwestern. During her fellowship we collaborated on 2 peer-reviewed research articles in the field of adolescent medicine. Upon completion of her fellowship, Dr. Musacchio took a junior faculty position at Northwestern but has since relocated to Dallas, TX where she has pursued a largely clinical career in adolescent medicine.
- 2009-11 Nadia Dowshen MD. I was Dr. Dowshen's primary clinical and research mentor during her times as fellow in the Division of General Academic Pediatrics at Northwestern. During this time she gained both clinical and research expertise related to adolescent HIV. In 2010, Dr. Dowshen received the "New Investigator Award" from the Society of Adolescent Medicine for her work on religiosity as a protective factor for HIV among transgender women. Upon completion of her fellowship, Dr. Dowshen was able to transition to Children's Hospital of Philadelphia where she assumed the role of Medical Director of their adolescent HIV clinic. She recently received a K-award from the NIMH for which I am key personnel on the mentorship team.
- 2011- Beau Gratzner PhD. I have been serving as a mentor for Beau as he completes his PhD in public health at the University of Illinois at Chicago. He has been serving as a Research Scientist in our Center for Gender, Sexuality and HIV Prevention and on completion of his PhD in the summer of 2013 he will transition in the role of Co-Investigator on a recently funded multicenter RO1 (RO1HD075655. Co-PIs: R. Stephenson, M. Mimiaga, R. Garofalo)
- 2011- Michelle Burns PhD. I serve as a mentor for the faculty development K Award that Dr. Burns received from the NIMH. Dr. Burns joined the faculty of Northwestern in the Department of Preventive Medicine. The research goal of the award is to develop a web-based intervention for young men who have sex with men who suffer from depression and/or anxiety.

- 2011- Joanna Olson MD. I serve as a research mentor for Dr. Olson who is a fellow in the Division of Adolescent Medicine at Los Angeles Children's Hospital. Her work is specific to the development of a research agenda related to the health and wellbeing of gender nonconforming children and adolescents. We are working together with the NICHD and colleagues from UCSF and Boston Children Hospital on establishing the first NIH-sponsored multicenter research network doing longitudinal research on gender nonconforming children and adolescents. We have planned a RO1 submission for Fall 2013.
- 2012- Travis Gayles MD, PhD. I am Dr. Gayles mentor for a NIMH-funded Diversity Supplement to our Life Skills RO1 focused on HIV prevention among young transgender women (RO1MH094323. Co-Pis: R. Garofalo/M. Mimiaga). The focus of Dr. Gayles' work during this fellowship award will be to conduct research related to bullying among LGBT youth and how experiences of violence relate to engagement in other risk behaviors. We are also working on a number of faculty development awards as well as independent investigator awards to help him transition to a faculty role at Northwestern.
- 2012- Michael Schelendich, Patrick Hrley, Alejandro Gonzalez. Research mentor for the new curriculum in Northwestern Medical School where first year medical students get formal mentored experiences in research.

#### **EDITORIAL RESPONSIBILITIES**

- 2002 Guest Editor: The At-Risk Adolescent. *Pediatric Annals*. 2002, 31(9).  
 2012- Editorial Board. Journal of LGBT Health

#### **REVIEW RESPONSIBILITIES**

- 2006-10 NIH Scientific Review Panel (HIV-Related Research Applications)  
 Washington D.C. – 1 meeting per year
- 2008 Scientific Grant Reviewer  
 American Foundation for AIDS Research; New York, NY
- 2009 Scholarly Reviewer. National Research Council Institute of Medicine; Washington, DC  
 Adolescent Health Services: Highlights and Considerations for State Health Policymakers
- 2010 Scientific Grant Reviewer  
 American Foundation for AIDS Research; New York, NY
- 2010-14 NIH Study Section Committee Member. AIDS and Related Research IRG. Behavioral and Social Consequences of HIV/AIDS NIH Study Section; Bethesda, MD
- 2012 NICHD *Population Sciences Subcommittee* (CHHD-W) Grant Review; Bethesda, MD

#### **GRANT ACTIVITY: PROGRAM SUPPORT**

- 2001- *Health Resource Service Administration* (HRSA): Ryan White Title IV Adolescent Initiative, Washington, DC. \$360,000 annually  
Project Director/Principal Investigator: PATH Youth Network. This grant provides operating support for a multi-disciplinary adolescent HIV collaborative between Howard Brown Health Center and Children's Memorial Hospital.
- 2002-03 *Lloyd A. Fry Foundation*, Chicago, IL. \$35,000  
Project Director: Uptown Teen Health Center. This grant provides general operating start-up support for the development of a teen health center.
- 2002-04 *AIDS Foundation of Chicago*, Chicago, IL. \$35,000 annually  
Project Director: Prevention for Positives Initiative. This grant provides support for the development of an HIV secondary prevention program targeting adolescents perinatally infected with HIV.
- 2003-05 *Polk Brothers Foundation*, Chicago, IL. \$35,000 annually  
Project Director: Youth Drop-In Program. This grant provides general operating support, and support specific to mental health services, peer education, and HIV/STD testing and counseling for a community-based youth drop-in center targeting gay, lesbian, bisexual, and transgender youth.

- 2003-06 *United Way Foundation*, Chicago, IL. \$35,000 annually  
Project Director: Youth Drop-In Program. This grant provides general operating support, and support specific to mental health services, peer education, and HIV/STD testing and counseling for a community-based youth drop-in center targeting gay, lesbian, bisexual, and transgender youth.
- 2004-06 *United Way Foundation*, Chicago, IL. \$70,000 annually.  
Project Director. This grant is for the development of an innovative youth mentorship program which pairs at-risk LGBT youth with trained LGBT adult mentors. This program is the first of its kind in the U.S.
- 2006-11 Centers for Disease Control and Prevention, Atlanta, GA. \$350,000 annually  
Principal Investigator: Adapting HIV Behavioral Interventions for Transgender Youth of Color (TWISTA)  
 This project requires the adaptation and diffusion of an effective behavioral intervention tailored to the HIV-risk mechanisms of transgender youth from communities of color age 16-24.
- 2012-15 Chicago Department of Public Health. \$67,500 annually  
Project Director. This grants fund the “Out and About” Program at Lurie Children’s which is a HIV prevention program that provides outreach, education and HIV testing and counseling to young men who have sex with men on the North side of Chicago
- 2012-15 Chicago Department of Public Health. \$100,000 annually  
Project Director. This grants fund the “Linkage-to-Care” Program at Lurie Children’s which provides young people living with HIV with intensive and personalized support in accessing and maintaining medical care and referrals to other support services.
- 2012-15 Chicago Department of Public Health. \$70,000 annually  
Project Director. This grants fund the “Transcend” Program at Lurie Children’s which provides outreach, education and HIV testing and counseling to transgender women of all ages across the city of Chicago.
- 2012-15 Tawani Foundation. Chicago, IL. \$475,000 total award  
Director. This award provides seed monies for the development of the Midwest’s first multidisciplinary clinical program devoted to the care of gender non-conforming children and adolescents located at Lurie Children’s Hospital.
- 2012-17 *Health Resource Service Administration (HRSA) Special Projects of National Significance*.  
Medical Director. TransLife Care Project. This SPNS project related to the health of HIV+ transgender women is being done in coordination with community-based partners in Chicago House and Healthland Health Alliance. Chicago House is the awardee and our role is the coordination of linkage-to-care and retention in care of HIV+ transwomen.

**GRANT ACTIVITY: RESEARCH**

**Completed Research Support:**

- K12 RR01777 P. Greenland (PI) 10/01/03 – 9/30/06  
 NCRR R. Garofalo (Awardee)  
 Mentored Clinical Scholars Program (Northwestern University)  
 This 3 year mentored faculty award provided 75% faculty support for career development related to clinical/behavioral research. This specific proposal focused on determinants of HIV risk for acquiring HIV among LGBT youth.
- R03 MH070812 R. Garofalo (PI) 7/01/04 - 6/30/06  
 NIMH  
*HIV Risk in Vulnerable Adolescents*  
 This project will explore unique mechanisms of risk for acquiring HIV among lesbian, gay, bisexual and transgender youth age 16-24. The major goal of this study is to test the utility of a Social-Personal

Theoretical Model in explaining HIV-related sexual risk in this vulnerable population of youth. The data will be used to inform the development of HIV prevention interventions tailored to the unique mechanisms of risk for this adolescent/young adult subgroup.

ATN 039 M. Belzer (PI) 1/01/04 - 4/01/06  
 NICHD R. Garofalo (Co-PI)

*Transgender Youth Research Project*

Using the framework of Bronfenbrenner's Social-Ecological Model of risk behaviors, his multi-site project uses quantitative and qualitative methodology to explore factors associated with HIV risk in transgender youth age 14-24. The data will be used to inform the development of HIV prevention interventions geared to the unique mechanisms of risk of this high-risk adolescent and young adult subgroup.

UR6 PS000396 R. Garofalo (PI) 9/1/06 – 8/31/08  
 CDC

*Life Skills Intervention: Safety & Coping Among Transgender Youth and Young Adults*

This study, funded by the HIV prevention research branch of the CDC, is to develop and pilot test and HIV prevention intervention for at-risk transgender youth age 14-24. The developed multi-dimensional intervention will be based upon Bronfenbrenner's Social-Ecological Model.

R34 MH079714 B. Mustanski (PI) 6/1/07 – 5/31/10  
 NIMH R. Garofalo (Co-I)

*Internet-based HIV/STI prevention for young MSM receiving HIV testing*

This three year study involves using the Transtheoretical Model of Behavior Change for the phased development and testing of an online HIV prevention program targeting the unique mechanisms of risk of young adult men who have sex with men (MSM) age 18-24 who recently tested negative from HIV.

R34 MH079707 R. Garofalo (PI) 9/1/07 – 11/31/10  
 NIMH

*Intervention Development: Reducing HIV Risk in Vulnerable Youth*

This three year study supports the development of a group-based intervention for an ethnically-diverse sample of young men who have sex with other men age 14-20. The intervention, based upon the Social-Personal Model of HIV Risk, will target the unique mechanisms of this high-risk adolescent population.

U01 HD052172 R. Garofalo (PI) 0/1/06 – 2/28/12  
 NICHD

*The PATH Youth Program: HIV/AIDS Interventions in Adolescents*

This award is for our site to be a member of the Adolescent Medicine Trials Network (ATN). The ATN conducts clinical and behavioral research projects with HIV+ adolescents and youth at risk of acquiring HIV.

R01HD051438 S. Eyre (PI) 7/1/06 – 6/30/11  
 NICHD R. Garofalo (Co-I)

*Cultural Predictors of HIV Risk in African-American Adolescents*

This award is for a qualitative and ethnographic study seeking to understand the cultural underpinnings of HIV in African-American male and female adolescents. This is a 3 site study: San Francisco, CA; Chicago, IL; and Birmingham, AL.

ATN082 S. Hosek (PI) 7/1/07-5/31/11  
 NICHD R. Garofalo (Site PI and Co-I)

*Evaluating the Feasibility and Acceptability of Pre-Exposure Prophylaxis HIV Prevention among YMSM*

This pilot RCT study examined the feasibility and acceptability of using a pre-exposure prophylaxis HIV prevention strategy among YMSM living in Chicago ages 18-22. The study was conducted as part of the Adolescent Medicine Trials Network

ONGOING RESEARCH SUPPORT

U01 AI 069512 R. Yogev (PI) 12/1/06 – 11/30/13

NIAID **R. Garofalo** (Co-I)

*IMPAACT: Units for HIV/AIDS Clinical Trials Network*

This award is for the establishment of a domestic and international pediatric and adolescent HIV/AIDS clinical trials network based out of Children's Memorial Hospital.

R01DA025548 **R. Garofalo/B. Mustanski** (PIs) 4/1/09 – 01/31/14  
NIDA

*Syndemic Development and HIV Risk Among Vulnerable Young Men*

This project will investigate a syndemic of psychosocial health issues linked to HIV among YMSM ages 16-20. This syndemic includes HIV risk, drug use, internalizing mental health problems, and violence exposure. The overarching goals of this study are twofold: 1) to provide much-needed epidemiological data on the prevalence of HIV and related health issues in order to inform public health priorities; and 2) to collect vital information on risk and protective factors to inform the development of an intervention targeting this vulnerable population.

R34DA031053 **R. Garofalo** (PI) 9/01/11 – 8/31/13  
NIDA

*Text Messaging Intervention to improve Adherence Among HIV-positive Youth and Young Adults.*

This study is a randomized controlled trial which will test the efficacy of a SMS text messaging intervention on antiretroviral adherence rates among non-adherent youth and young adults living with HIV, ages 16-29.

R01MH094323 **R. Garofalo/M. Mimiaga** (PIs) 6/13/11 – 3/31/16  
NIMH

*HIV Prevention Intervention for Young Transgender Women.*

The purpose of this study is to test the efficacy of a uniquely targeted HIV risk reduction intervention for young transgender women (YTW), ages 16 to 24, at risk for HIV acquisition or transmission.

R34MH097622 J. Schneider (PI) 3/1/12-2/28/15  
NIMH **R. Garofalo** (Co-I)

*Network Supported Engagement in HIV Care for Younger Black Men*

The goal of this project is to refine and pilot test a flexible Network Supported Engagement in Care (NSEC) intervention that recruits and motivates one or more organic social support network members of recently HIV diagnosed young black men who have sex with men (YBMSM) to improve engagement in HIV primary care.

R01HD075655 R. Stephenson/M. Mimiaga/**R. Garofalo** (PIs) 4/1/13-3/31/18  
NICHD

*Couples-based Voluntary HIV Testing and Counseling Plus among MSM*

From a sample of 3,360 MSM in Atlanta, Boston, and Chicago, 250 HIV-serodiscordant couples will be randomized to either Individual or Couples HIV Counseling and Testing, and then followed prospectively for two years. Couples randomized to couples-based counseling and testing will also receive a dyadic adherence intervention, with the research aimed to determine if couples testing together impacts linkage to HIV care, retention in HIV care, ART adherence and viral suppression.

R01MH100021 K. Fujimoto/J. Schneider 7/1/13-6/30/13  
NIMH **R. Garofalo** (Co-I)

*Social Network Analysis and HIV Risk among YMSM*

Younger men who have sex with men (YMSM) are at increased risk of HIV and STIs in the United States. The goal of the proposed longitudinal network study is to investigate the complex interactions between YMSM and both preventive health venues and risk venues to gain a deep understanding of the

sometimes conflicting influences and complex interactions that may also provide risk and protection in the same venue.

**INVITED LECTURES AND SYMPOSIA: GRAND ROUNDS/PLENARY SPEAKER (SELECTED)**

- Mar. 1999 Supporting personal growth and community development among GLBT youth.  
Boston Symposium on Youth Development. (CME)  
Boston, MA.
- Aug. 1999 Talking about sex: Teaching providers the importance of a comprehensive and sensitive sexual history. National Gay and Lesbian Medical Association Conference. (CME)  
San Diego, CA.
- Mar. 2000 Adolescent health and HIV.  
Massachusetts College of Pharmacy. (CME – Grand Rounds)  
Boston, MA.
- Apr. 2000 Caring for adolescents infected with HIV.  
University of Massachusetts Medical School/New England AIDS Education & Training Center.  
(CME)  
Worcester, MA.
- Aug. 2000 Seeing the glass as half full vs. of half empty: changing the face of GLBT youth.  
Gay and Lesbian Medical Association Conference. (CME – Keynote Address)  
Vancouver, Canada.
- Oct. 2000 Diversity in clinical practice: The story of GLBT youth.  
American Academy of Pediatrics Annual Meeting.  
Chicago, IL.
- Nov. 2000 Re-thinking our GLBT youth community.  
Massachusetts Medical Society Annual Conference. Waltham, MA
- Nov.2001 Health care issues of gay and lesbian youth.  
Connecticut AIDS Education and Training Center – Growing Up With HIV Conference.  
(CME)  
Hartford, CT.
- Feb. 2002 Adolescent HIV: Trends, Opportunities, and Challenges.  
Children’s Memorial Hospital. (CME – Pediatric Grand Rounds)  
Chicago, IL
- June 2002 Adolescent health and the law.  
4<sup>th</sup> Annual Chicago Conference on Adolescent HIV. (CME)  
Chicago, IL.
- Sep. 2002 Teaching residents about adolescents and HIV.  
Mt. Sinai Hospital. Department of Pediatrics. (CME – Pediatric Grand Rounds)  
Chicago, IL
- Mar. 2003 Adolescent HIV: Fighting the HIV crisis in the African-American community.  
Center of the Study of Race and Bioethics, DePaul University.  
Chicago, IL.
- April 2003 Club drugs: Is it all ecstasy.  
Children’s Memorial Hospital Pediatric Pearls Conference. (CME)  
Oakbrook, IL
- May 2003 Adolescent HIV in Ethnic Minority Communities.  
Hispanocare -4<sup>th</sup> Annual Conference on HIV in the Hispanic and Latino Community.  
(CME)  
Chicago, IL
- Sept. 2003 Club drugs: An emerging epidemic in adolescents.  
Northwestern Evanston Hospital. (CME -- Pediatric Grand Rounds)  
Evanston, IL
- June 2003 Health care issues of transgender youth.  
5<sup>th</sup> Annual Chicago Conference on Adolescent HIV. (CME)

- Chicago, IL  
Dec. 2003 Mentorship, access, and politics: threats to adolescent health and well-being.  
Albert Schweitzer Fellowship Symposium.  
Chicago, IL
- Feb. 2004 Overlooked, misunderstood, and at-risk: managing the health care of transgender youth.  
John G. Stroger Hospital/Chicago Medical School. (CME – Pediatric Grand Rounds)  
Chicago, IL
- Mar. 2004 Adolescent HIV 2004 Update  
University of Hawaii/John A Burns School of Medicine (CME –Pediatrics Grand Rounds)  
Honolulu, HA
- Nov. 2006 Adolescent HIV: Epidemiology and health care challenges.  
Yale University School of Medicine (CME – Pediatric Grand Rounds)  
New Haven, CT
- Nov. 2006 Unfinished business: HIV prevention & U.S. adolescents.  
Yale University School of Medicine (CME)  
New Haven, CT
- Nov. 2006 Testing those at highest risk: What works with youth?  
NIH/CDC-sponsored conference: Opportunities for Improving HIV Diagnosis, Prevention  
and Access to Care in the U.S.  
Washington D.C.
- Jan. 2007 Adolescent health care services and systems: Issues of LGBTQ youth  
Institute of Medicine/National Academies of Sciences Board on Children, Youth, and  
Families – Research Workshop on Adolescent Health Care Services and Systems  
Washington D.C.
- Jun. 2008 Reversing the HIV epidemic in gay America: An honest conversation about our present  
and our future  
10<sup>th</sup> Iowa HIV/AIDS Conference; Des Moines, IA
- Sep. 2008 HIV prevention and transgender youth  
Pediatric Grand Rounds: University of Chicago Department of Pediatrics  
Chicago, IL (CME)
- Oct. 2008 AIDS activism before HIV: Understanding the FDA policy on blood donation  
University of Illinois at Chicago  
Chicago, IL
- Nov. 2008 HIV prevention research and intervention development in transgender populations  
Warren Wright Lecture Series  
Northwestern University/Children’s Memorial Hospital; Chicago, IL
- Feb. 2009 Understanding HIV risk in male-to-female transgender youth & developing interventions  
for an underserved population  
17<sup>th</sup> Annual John P. Johnson Memorial Lecture. Department of Pediatrics Grand Rounds  
The University of Maryland School of Medicine; Baltimore, MD (CME)
- July 2009 Seeing the glass as half-full: Gaining a better understanding of LGBT youth  
American Medical Association – Invited lecture  
Chicago, IL
- Oct. 2009 Providing HIV care to youth and young adults  
University of Colorado Conference on HIV/AIDS; Denver CO (CME)
- Nov. 2009 Caring for LGBT Youth in a Clinical Environment  
Keynote Speaker: 40<sup>th</sup> Annual Robert Warren MD Memorial Seminar; Wilmington DE  
(CME)
- Jan. 2010 Substance use & HIV  
Loyola University Department of Medicine Grand Round  
Loyola University of Chicago, Chicago, IL (CME)
- Jun 2010 Resiliency in LGBT Youth  
Fenway Institute National Men’s Summit; Boston, MA
- Oct. 2010 Primary care for the transgender adolescent

- Mar. 2011 Indiana University Division of Adolescent Medicine; Indianapolis, IN (CME)  
Addressing Transgender Health: Inspirations, the IOM and Tipping Points  
National Transgender Health Summit
- May 2011 University of California at San Francisco; San Francisco, CA  
Tipping points: The IOM and LGBT health  
2<sup>nd</sup> Annual John Money Lecture – 1<sup>st</sup> Annual Lecture for Jocelyn Elders Endowed Chair  
University of Minnesota Program in Human Sexuality, Minneapolis, MN
- June 2011 Meeting the Recommendations of the IOM  
National Institute of Drug Abuse (NIDA) – Invited lecture  
Bethesda, MD
- July 2011 Developing HIV prevention programs for YMSM and transgender youth  
Grand Rounds Department of Pediatrics  
Children’s Memorial Hospital/Northwestern University; Chicago, IL (CME)
- Aug. 2011 LGBT youth and primary care  
National Association of Community Health Center Annual Conference  
San Diego, CA (CME)
- Sep. 2011 U.S. models for caring for transgender youth  
World Professional Association of Transgender health (WPATH); Atlanta, GA
- Jan. 2012 LGBT youth and the pediatric primary care provider  
Pediatric Grand Rounds  
Cardinal Glennon Children’s Medical Center; St. Louis, MO (CME)
- May 2012 Understanding HIV Risk and Developing Prevention Interventions for YMSM  
Grand Rounds – Division of Adolescent Medicine  
National Children’s Medical Center; Washington DC (CME)
- Jun. 2012 Homelessness and LGBT youth  
National Runaway Switchboard Homeless Coalition; Nashville, TN (CME)
- Jan 2013 LGBT health issues and adolescent sexuality  
Grand Rounds Department of Pediatrics  
Comer Children’s Hospital/University of Chicago; Chicago, IL (CME)
- Jan 2013 Caring for LGBT youth with an academic health care center  
Grand Rounds Department of Pediatrics  
Rush University and Stroger Hospitals; Chicago, IL (CME)
- April 2013 Developing HIV prevention interventions for YMSM and transgender youth  
NIH Academy  
Bethesda, MD

**RESEARCH PRESENTATION**

- Mar. 1997 Health risk behaviors and sexual orientation among a school-based sample of adolescents.  
Oral Presentation: Society for Adolescent Medicine Annual Conference  
San Francisco, CA
- May 1998 Sexual orientation and suicide risk among a representative sample of youth  
Oral Presentation: Pediatric Academic Societies’ Meeting  
New Orleans, LA
- Nov. 1998 Clustering of risk behaviors among gay youth.  
Oral Presentation: American Public Health Association Annual Conference  
Indianapolis, IN.
- Mar. 2001 Perceived quality of life of at-risk youth: A non-traditional health center's perspective  
Poster Presentation: Society for Adolescent Medicine Annual Conference  
San Diego, CA
- May 2004 Overlooked, misunderstood and at-risk: A descriptive study of ethnic minority transgender youth.  
Poster Presentation: Pediatric Academic Societies’ Meeting  
San Francisco, CA



- Oct. 2004 Understanding the health and psychosocial risk of transgender youth  
Oral Presentation: Gay and Lesbian Medical Association Conference  
Palm Springs, CA
- June 2005 Environmental and psychosocial correlates of high-risk sexual activity among ethnic-  
minority transgender youth  
Oral Presentation: National CDC HIV Prevention Conference  
Atlanta, GA
- June 2005 Tip of the iceberg: Young men who have sex with men, the Internet and HIV risk  
behaviors  
Oral presentation: National CDC HIV Prevention Conference  
Atlanta, GA
- Mar. 2006 Online and at-risk: Young men who have sex with men and the Internet.  
Oral Presentation: Society for Adolescent Medicine Annual Conference  
Boston, MA
- Oct. 2006 Young MSM and the Internet: HIV Risk and Sexual Behaviors  
Oral Presentation: Gay and Lesbian Medical Association Conference  
San Francisco, CA
- Nov 2008 Understanding HIV Risk in MTF Transgender Youth and Developing HIV Prevention  
Programs for this Vulnerable Population  
Oral Presentation: Society for the Scientific Study of Sexuality  
San Juan, PR
- Nov 2008 Exploring Racial/Ethnic Disparities in HIV Risk in Young Men who have Sex with Men  
Oral Presentation: Society for the Scientific Study of Sexuality  
San Juan, PR
- Nov 2010 The Presence and Availability of Role Models among LGBT Youth  
Oral Presentation: Society for the Scientific Study of Sexuality  
Puerto Vallarta, Mexico
- May 2011 Text Messaging and Adherence to Medications among HIV+ Youth  
Oral Presentation: International Association of Providers of AIDS Care Adherence  
Conference  
Miami, FL

### **SCHOLARLY PRODUCTIVITY:**

#### REFEREED JOURNAL ARTICLES

- Garofalo R**, Wolf RC, Kessel S, Palfrey J, DuRant RH. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*.1998; 101(5): 895-902.
- Garofalo R**, Wolf RC, Woods ER, Wissow L, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatric and Adolescent Medicine*.1999;153: 487-493.
- Garofalo R**, Chadwick EG, Yogev R. Mycobacterium gordonae bacteremia in an asymptomatic adolescent with AIDS. *The Pediatric Infectious Disease Journal*. 2003; 22(6).
- Garofalo R**, DeLeon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*. 2006; 38:230-236.
- Musacchio N, Hartrich M, **Garofalo R**. Erectile dysfunction and Viagra™ use: What's up with college-age males. *Journal of Adolescent Health*. 2006. 39: 452-454.
- Garofalo R**, Osmer E, Doll M, Sullivan C, Harper GR. Environmental, psychosocial and individual correlates of HIV risk in ethnic minority male-to-female transgender youth. *Journal of HIV/AIDS Prevention in Children & Youth*. 2006. 7(2): 89-104.
- Garofalo R**, Herrick A, Mustanski BS, Donenberg GR. Tip of the iceberg: Young men who have sex with men, the Internet and HIV risk. *American Journal of Public Health*. 2007. 97(6): 1113-1117.

- Garofalo R**, Mustanski BS, McKirnan D, Herrick A, Donenberg GR. Methamphetamine and young men who have sex with men: Understanding patterns and correlates of use and the association with HIV-related sexual risk. *Archives of Pediatr and Adolescent Medicine*. 2007. 161: 591-596.
- Mustanski M, **Garofalo R**, Herrick A, Donenberg GR. Psychosocial health problems increase risk for HIV among urban young men who have sex with men: Preliminary evidence of a syndemic in need of attention. *Annals of Behavioral Medicine*. 2007;34(1)37-35.
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- Musacchio NS, Gehani S, **Garofalo R**. Emergency department management of adolescents with urinary complaints: Missed opportunities. *Journal of Adolescent Health*. 2009. 44: 81-83.
- Wilson EC, **Garofalo R**, Harris RD, Herrick AL, Martinez M, Martinez J, Belzer M. Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS Behav*. 2009. 13(5):902-13
- Dowshen N, Binns H, Garofalo R. Experiences of HIV-related stigma among young men who have sex with men. *AIDS Patient Care and STDs*. 2009. 23 (5):371-376.
- Herrick AL, Matthews AK, **Garofalo R**. Health risk behaviors in an urban sample of young women who have sex with women. *Journal of Lesbian Studies*. 2010. 14(1): 80-92.
- Wilson EC, **Garofalo R**, Harris RD, Martinez J, Belzer M. Sexual risk-taking among transgender male-to-female youths with different partner types. *Am J Public Health*. 2010. 100(8):1500-5. [PMC2901273].
- Garofalo R**, Mustanski, B, Johnson A, Emerson, E. Exploring Factors That Underlie Racial/Ethnic Disparities in HIV Risk among Young Men Who Have Sex with Men. *Journal of Urban Health*. 2010. 87(2): 318-323.
- Mustanski, B, **Garofalo R**, Emerson E. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youth. *Am J Public Health*. 2010. Dec; 100(12): 2426-32.
- Dowshen N, Forke CM, Johnson AK, Kuhns, LM, Rubin D, **Garofalo R**. Religiosity as a protective factor against HIV risk among young transgender women. *Journal of Adolescent Health*. 2011. Apr; 48(4):410-414.
- Mustanski B, Newcomb ME, **Garofalo R**. Mental health of lesbian, gay and bisexual youths: A developmental resiliency perspective. *Journal of Gay and Lesbian Social Services*. Jun 2011. 23:2, 204-225.
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- Garofalo R**, Johnson AK, Kuhn LM, Cotton C, Joseph H., Margolis A. Life skills: Evaluation of a theory-driven behavioral HIV prevention intervention for young transgender women. *Journal of Urban Health*. 2012;89(3):419-431.
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- Dowshen N, Kuhns L, Johnson AK, Holoyda B, **Garofalo R**. Improving Adherence to Antiretroviral Therapy for Youth Living with HIV/AIDS (YLH): A pilot study using personalized, interactive, daily text message reminders. *Journal of Medical Internet Research*. 2012; 14(2):168-175.
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- Robert Garofalo, Colleen Monahan, , Beau Gratzner, Rebecca Andrews Feasibility, Acceptability, and Preliminary Efficacy of an Online HIV Prevention Program for Diverse Young Men who have Sex with Men: The Keep It Up! Intervention
- Lyons, T., Johnson, A., **Garofalo, R**. "What could have been done different?": A qualitative study of syndemic theory and HIV prevention among young men who have sex with men. *Journal of HIV/AIDS and Social Services*. In press
- Newcomb ME, Ryan DT, **Garofalo R** & Mustanski B. The effects of sexual partnership and relationship characteristics on three sexual risk variables in young men who have sex with men. *Archives of Sexual Behavior*
- Hosek S, Siberry G, Bell M, Lally M, Kapogiannis B, Green K, Fernandez I, Rutledge B, Martinez J, **Garofalo R**, Wilson C, and the Adolescent Trials Network for HIV/AIDS interventions (ATN). The acceptability and feasibility of an HIV pre-exposure prophylaxis trial with young men who have sex with men (YMSM). *JAIDS*. In Press.
- Everett B, Scnarrs P, **Garofalo R**, Rosario M, Mustanski B. Sexual orientation disparities in STI risk behaviors and risk determinants among sexually active adolescent males: Results from a school-based sample. *American Journal of Public Health*. In Press

NON-REFEREED JOURNALS/REVIEW ARTICLES

- Garofalo R**, Makadon H. Management of the Asymptomatic HIV Infection: An Update. *Hospital Practice*. 2000; 35(3):89-101.
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- Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyeler E, **Garofalo R**, Karasic DH, Lev AI, Mayer G, Meyer-Bahlburg H, Hall BP, Pfaefflin F, Rachlin K, Robinson B, Schechter LS, Tandgpricha V, von Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*. 2011;13:165-232.
- Mayer K, Makadon H, **Garofalo R**. Risk to resilience: How clinical providers and public health programs can promote the successful development of sexual and gender minority youth. In Press. *AJPH*.

**Garofalo R.** A personal reflection on the history of population-based research with sexual minority youth. In Press. *AJPH*

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IOM (Institute of Medicine). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington DC: The National Academies Press. 2011

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Guest Editor: The At-Risk Adolescent. *Pediatric Annals*. 2002, 31(9).

BOOKS AND BOOK CHAPTERS

**Garofalo R** and Makadon H. HIV prevention in clinical practice. In: The HIV Manual – 3<sup>rd</sup> Edition. American College of Physicians. 2000 [ Revised in 2003]

**Garofalo, R.** Adolescent sexuality. In: UpToDate, Rose, BD (Ed), UpToDate, Welleley, MA, 2002.

**Garofalo R.** Adolescent Medicine. In: Just the Facts in Pediatrics, McGraw-Hill, 2004.

**Garofalo R** and Bush S. Addressing LGBT youth in the clinical setting. In: The Fenway Guide to Primary Care for the LGBT Community. American College of Physicians. 2010

Forcier M and **Garofalo R.** Adolescent sexuality. In: Comprehensive Adolescent Health Care – 3<sup>rd</sup> Edition. 2012

Gayles T and **Garofalo R.** Caring for LGBT youth. The Fenway Guide to Primary Care for the LGBT Community. American College of Physicians [In Press]

Dowshen N and **Garofalo R.**, Adolescent HIV in Ginsburg KR and Kinsman SB, eds. Reaching Teens: Wisdom from Adolescent Medicine. Elks Grove Village IL; American Academy of Pediatrics; In Print for 2013. (A Textbook and Video Product) In Production/Press

ABSTRACTS

**Garofalo R,** Sherrit L, Austin S, Palfrey J. Perceived quality of life of at-risk youth: a non-traditional health center's perspective. *Journal of Adolescent Health*. 2001

**Garofalo R.** Herrick A, Mustanski BS, Donenberg GR. Online and at-risk: Young men who have sex with men and the Internet. *Journal of Adolescent Health*. 2006

# **Exhibit B**

## Exhibit B

### Selected Bibliography to the Expert Declaration of Robert Garofalo, M.D., M.P.H.

- Marco A. Hidalgo, Diane Ehrensaft, Amy C. Tishelman, Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack & Johanna Olson, *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 HUMAN DEVELOPMENT 285 (2013).
- Kenneth H. Mayer, Robert Garofalo & Harvey Makadon, *Promoting the Successful Development of Sexual and Gender Minority Youths*, 104 AMERICAN JOURNAL OF PUBLIC HEALTH 976 (2014).
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