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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

AURORA REGINO,

Plaintiff,

v.

SUPERINTENDENT KELLY STALEY, in her official capacity; CAITLIN DALBY, in her official capacity; REBECCA KONKIN, in her official capacity; TOM LANDO, in his official capacity; EILEEN ROBINSON, in her official capacity; and MATT TENNIS, in his official capacity,

Defendants.

Case No._____

VERIFIED COMPLAINT

Jury Trial Demanded

Plaintiff, Aurora Regino, by and through her undersigned counsel, states the following claims for relief against Defendants, each in their official capacity only, and respectfully requests that this Court render a declaratory judgment and preliminary and permanent injunction against Defendants' ongoing violations of the United States Constitution as set forth herein. In support of her claims, Ms. Regino states as follows:

INTRODUCTION

1. The Due Process Clause of the Fourteenth Amendment to the United States Constitution protects parents' fundamental right to direct the upbringing of their children. This protection includes parents' right to be involved in the decision-making process when a public school decides to socially transition their children from one gender to another.[1] Social transitioning is a powerful psychological intervention affecting a matter of major importance to a child's life—namely, his or her gender identity. Absent a compelling state interest, which is not present here, public schools may not socially transition children without first informing and receiving consent from their parents.

2. Like many public-school districts in California, the Chico Unified School District (the "District") has adopted a policy (the "Parental Secrecy Policy" or the "Policy") under which schools in the District will (1) socially transition students who

[1] "Social transitioning" refers to the active affirmation of a transgender identity. *See* Affidavit of Dr. Stephen B. Levine, dated January 5, 2023 ("Levine Affidavit") ¶ 12f, attached hereto as Exhibit A. In children, it includes things like calling the child by a new name associated with their new gender, referring to the child by pronouns associated with their new gender, and allowing the child to use public bathrooms associated with their new gender. *Id.*

express a desire to live as a gender different from that associated with their biological sex while (2) keeping the social transitioning secret from their parents unless the student specifically authorizes the school to inform them. Under the Parental Secrecy Policy, schools in the District are prompting students to question their sexuality and gender, facilitating their social transition to a new gender identity, and integrating this new person into the school ecosystem, all without informing or receiving consent from their parents. Even if the parents would be supportive of their children—as Ms. Regino was here—the Parental Secrecy Policy precludes parents from being a part of this significant and formative event in their children's lives.

3. Ms. Regino's oldest daughter, A.S., was a fifth-grade student at an elementary school operated by the District during the 2021–2022 school year. In early 2022, when A.S. was eleven years old, she informed a school counselor that she "felt like a boy." Within minutes of A.S. making that statement, the counselor encouraged A.S. to adopt a male identity, which included using a male name and male pronouns. After the meeting, the counselor walked A.S. back to class and informed A.S.'s teacher about A.S.'s new identity. Over the following months, the District used A.S.'s male name and pronouns while at school, and the school counselor provided A.S. with additional information about continuing her transition to a male identity. All of this was kept hidden from A.S.'s mother.

4. After several weeks of A.S. identifying as a boy at school, Ms. Regino learned about A.S.'s new gender identity. Ms. Regino was supportive of A.S. but upset that the school had not even informed her that it was socially transitioning her

daughter from a girl to a boy. She tried to encourage the District to abandon the Parental Secrecy Policy in favor of a policy that would involve parents in students' gender transitions, but she was told that the Policy was required by California law. This is false.

5. Despite the District's efforts to socially transition A.S. to a boy, she has, for now, returned to identifying as a girl. She believes her feelings of gender confusion were brought on by the stress of other difficulties in her life. She attends regular counseling sessions with a private therapist to help her to cope with these stressors.

6. By socially transitioning A.S. without informing Ms. Regino or obtaining her consent, the District violated Ms. Regino's fundamental right to direct the upbringing of her child. Parents, not schools, have the right and responsibility to make major life decisions on behalf of their minor children. That right is infringed when schools socially transition children from one gender to another without involving their parents.

7. Ms. Regino brings this action to vindicate that right. Both of her children still attend school in the District, and the District continues to adhere to the Parental Secrecy Policy. Accordingly, Ms. Regino's parental rights are subject to an ongoing threat. She seeks (1) a declaratory judgment declaring the Parental Secrecy Policy unconstitutional and (2) a preliminary and permanent injunction precluding the District from continuing to enforce the Policy.

JURISDICTION AND VENUE

8. This action arises under the Fourteenth Amendment to the United States Constitution, 42 U.S.C. § 1983, and 28 U.S.C. §§ 2201 and 2202.

9. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331.

10. Venue is proper in this judicial district under 28 U.S.C. § 1391(b)(2) because a substantial part of the events giving rise to Ms. Regino's claims occurred within the Eastern District of California.

THE PARTIES

11. Plaintiff Aurora Regino is a resident of Chico, California. She is a single mother with sole custody over her two minor daughters, A.S. and C.S., both of whom live with her. At all relevant times to this Complaint, both A.S. and C.S attended—and still attend—schools operated by the District. Ms. Regino is a fit parent, is actively involved in her children's lives, loves her children dearly, seeks to do what is best for them, and wishes to provide them with the nurturing and guidance of a loving and caring mother in all aspects of their lives. To that end, Ms. Regino engages with her children's schools to ensure that she is informed about what occurs in their lives when they are not at home. She intends to continue this level of involvement in her children's lives.

12. The District is a public school district based in Chico, California. It operates twenty-three schools—twelve elementary schools, four junior high schools, three high schools, and four other schools. *See* http://www.chicousd.org/Schools/Our-Schools/index.html, last visited on January 5, 2023, attached hereto as Exhibit B. Over 12,000 students attend school in the District. *See* http://www.chicousd.org/Our-District/index.html, last visited on January 5, 2023, attached hereto as Exhibit C.

13. The District is governed by the Chico Unified School District Board of Education (the "Board"). *See* http://www.chicousd.org/Our-District/Board-Trustee-

Information/index.html, last visited on January 5, 2023, attached hereto as Exhibit D. The Board and its five Members are responsible for oversight, operations, and policy, which includes but is not limited to the Parental Secrecy Policy. *See id.*

14. Defendant Caitlin Dalby is a Member of the Board. *See id.* In this capacity, Ms. Dalby is responsible for oversight, operations, and policy, including but not limited to the Parental Secrecy Policy, at the schools within the District. *See id.* At all times relevant to this Complaint, Ms. Dalby was and will be acting under color of California law while performing her duties as a Board Member. Ms. Dalby is sued in her official capacity only.

15. Defendant Rebecca Konkin is a Member of the Board. *See id.* In this capacity, Ms. Konkin is responsible for oversight, operations, and policy, including but not limited to the Parental Secrecy Policy, at the schools within the District. *See id.* At all times relevant to this Complaint, Ms. Konkin was and will be acting under color of California law while performing her duties as a Board Member. Ms. Konkin is sued in her official capacity only.

16. Defendant Tom Lando is a Member of the Board. *See id.* In this capacity, Mr. Lando is responsible for oversight, operations, and policy, including but not limited to the Parental Secrecy Policy, at the schools within the District. *See id.* At all times relevant to this Complaint, Mr. Lando was and will be acting under color of California law while performing his duties as a Board Members. Mr. Lando is sued in his official capacity only.

17. Defendant Eileen Robinson is a Member of the Board. *See id.* In this

capacity, Ms. Robinson is responsible for oversight, operations, and policy, including but not limited to the Parental Secrecy Policy, at the schools within the District. *See id.* At all times relevant to this Complaint, Ms. Robinson was and will be acting under color of California law while performing her duties as a Board Member. Ms. Robinson is sued in her official capacity only.

18. Defendant Matt Tennis is a Member of the Board. *See id.* In this capacity, Mr. Tennis is responsible for oversight, operations, and policy, including but not limited to the Parental Secrecy Policy, at the schools within the District. *See id.* At all times relevant to this Complaint, Mr. Tennis was and will be acting under color of California law while performing his duties as a Board Member. Mr. Tennis is sued in his official capacity only.

19. Defendant Kelly Staley is the Superintendent of the District. *See* http://www.chicousd.org/Our-District/Superintendent/index.html, last visited on January 5, 2023, attached hereto as Exhibit E. In this capacity, Ms. Staley is responsible for overseeing the implementation of all District policies, including the Parental Secrecy Policy, and she has ultimate supervisory authority over all District employees, which includes all employees working at the schools within the District. At all times relevant to this Complaint, Ms. Staley and was and will be acting under color of California law while performing her duties as Superintendent. Ms. Staley is sued in her official capacity only.

FACTUAL ALLEGATIONS

The Parental Secrecy Policy

20. The District has adopted and implemented the Parental Secrecy Policy. Under this Policy, which is a policy, practice, procedure, and / or custom of the District, schools will (1) socially transition students who express a desire to live as a gender different from that associated with their biological sex while (2) keeping the social transitioning secret from their parents unless the student specifically authorizes the school to inform them. On information and belief, for the reasons set forth in Paragraph 53, the District applies the Parental Secrecy Policy at all schools within the District.

21. Under the Policy, schools accomplish social transitioning of students by, among other things, referring to students by a new name associated with their new gender, referring to students by pronouns associated with their new gender, and allowing students to use bathrooms associated with their new gender.

A.S. Joins Ms. Robinson's "Girls Group" at Sierra View

22. Ms. Regino's oldest daughter, A.S., is a twelve-year-old biological female. She is currently in sixth grade at Marsh Junior High ("Marsh"), one of the junior high schools in the District. During the 2021–2022 school year, A.S. attended fifth grade at Sierra View Elementary School ("Sierra View"), which is also in the District.

23. In the fall of 2021, A.S. began feeling depressed and anxious. She had just begun puberty, and there had been significant changes in her home life over the preceding months. Her grandfather had recently passed away and her mother (Ms.

Regino) had just completed treatment for breast cancer and was in the process of obtaining a degree in nursing. A.S.'s father is disabled due to an injury from an automobile accident and, as a result of the changes at home, A.S. began taking on a greater role in caring for her younger sister, C.S., who was seven years old at the time. The confluence of these events left A.S. feeling mentally exhausted and emotionally confused.

24. Mandi Robertson was a school counselor at Sierra View. Throughout the 2021–2022 school year, Ms. Robertson regularly visited A.S.'s class to remind them of the services the counselor's office provides.

25. One topic that Ms. Robertson regularly raised with the students was sexuality and gender identity. She would encourage students to explore their identity and consider whether they felt like they were not the gender associated with their biological sex. She explained that such feelings were normal and that students should embrace them.

26. A.S. took Ms. Robertson's advice. She wondered if her new feelings of anxiety and depression were because she was born the wrong gender. Around December 2021, A.S. began feeling like she might be a boy. These feelings were the result of her exploring her identity consistent with Ms. Robertson's instructions.

27. In December 2021, before winter break, A.S. met with Ms. Robertson to discuss her feelings. At that meeting, A.S. did not mention that she felt like a boy. Ms. Robertson encouraged A.S. to join a small group of other girls around her age that she (Ms. Robertson) organized when school resumed the following month (the

"Girls Group"). Ms. Robertson told A.S. that the group was primarily focused on arts and crafts, and that the group would be a good opportunity for A.S. to make new friends. Ms. Robertson provided A.S. with a permission slip for participation in the Girls Group to take home for her mother to sign.

28. Ms. Regino agreed that an arts-and-crafts group would facilitate positive social interaction for A.S. with other girls her own age and could help A.S. with her anxiety and depression. Ms. Regino approved of her daughter joining the Girls Group and signed the permission slip allowing A.S. to participate in the group once school began in the spring semester of 2022. The permission slip was for attendance at the Girls Group only, and *not* for one-on-meetings with Ms. Robertson.

29. On or about January 20, 2022, A.S. attended her first Girls Group meeting. The meetings included A.S. and about four of her female classmates, whose ages ranged from 10 to 12 years old. The first one or two meetings of the Girls Group were geared towards arts and crafts, as A.S. anticipated, but the subject of the meetings quickly changed.

Ms. Robertson and the District Socially Transition A.S.

30. After one or two Girl's Group meetings, A.S. went to Ms. Robertson's office to tell her that she "felt like a boy" or words of similar effect. Ms. Robertson asked A.S. if she had a boy's name that she would like to be called and whether she would like to be referred to by male pronouns. A.S. was unsure whether she wanted others at school to start calling her by a male name and pronouns, but she felt pressured by Ms. Robertson, so she responded in the affirmative and told Ms.

Robertson her boy's name was "J.S." During this meeting, Ms. Robertson did not discuss A.S.'s feelings of anxiety and depression. Instead, the discussion focused solely on how to effect A.S.'s social transition to a boy.

31. After the meeting, Ms. Robertson walked A.S. back to her classroom and told her teacher that A.S. was now going by the name "J.S." and male pronouns, and her teacher immediately began referring to her as such. Soon thereafter, other teachers and school employees also began referring to A.S. by "J.S." and male pronouns. A.S. did not fully understand what was happening, and she never authorized—or wanted—any District personnel other than Ms. Robertson or her teacher to refer to her by "J.S." or male pronouns.

32. Once A.S. "came out" to Ms. Robertson, the Girls Group meetings changed substantially. Instead of arts-and-craft projects, Ms. Robertson now led A.S. and her female classmates in a discussion regarding sexuality and gender identity. They discussed how to cope with feeling like a different gender—specifically, how embracing these feelings and transitioning can alleviate the pain and anxiety of living as the wrong gender.

33. Over the course of the spring semester of 2022, A.S. had two additional one-on-one meetings with Ms. Robertson. At these meetings, Ms. Robertson provided A.S. with additional resources regarding her new male identity, such as referring A.S. to a local community group that advocates for LGBTQ+ causes and discussing "breast binding" with her.[2] A.S. told Ms. Robertson that she wanted to tell her mother about

[2] "Breast binding" is the flattening of a biological female's breasts with constrictive clothing to make the chest appear flat.

her new identity, but Ms. Robertson was not supportive of this course of action. She brushed off A.S.'s request and encouraged her to speak with other family members first. At no time did Ms. Robertson suggest A.S. should discuss her feelings with a mental health professional.

34. During this time, school personnel continued referring to A.S. by her new name and pronouns. Every day at school, A.S. was known as "J.S." and referred to with male pronouns, while at home, she remained A.S. Despite requiring a parental permission slip for A.S. to participate in an arts-and-crafts club, the District socially transitioned A.S. from a girl to a boy without even *informing* her mother, much less obtaining her permission to do so.

A.S. "Comes Out" to her Grandmother but Returns to her Female Identity

35. On or about April 8, 2022, A.S. told her grandmother about her new identity. A.S.'s grandmother informed Ms. Regino of the news later that day.

36. Ms. Regino was surprised to learn of A.S.'s transition, and she was shocked that the District had socially transitioned A.S. without involving her, but she was—and is—supportive of her daughter. All she wanted—and wants—was for her daughter to be happy and healthy in whatever identity she chooses. Ms. Regino informed A.S. of her support and told her she would assist her with her transition if that was what she wanted. In addition, Ms. Regino arranged for A.S. to begin attending counseling sessions with a licensed marriage and family therapist to discuss her feelings of depression and anxiety.

37. Although Ms. Regino was supportive of her daughter, had Ms. Regino

been involved in the process, she would not have allowed Sierra View to socially transition her daughter without first seeking guidance from a mental health professional. Ms. Regino arrived at this view for several reasons, including but not limited to: A.S.'s young age; the quick onset of A.S.'s feelings of gender confusion; the fact that those feelings appeared to have originated with Ms. Robertson, not A.S.; the existence of other stressors in A.S.'s life that could potentially explain her feelings of gender confusion; and the short duration of A.S.'s feelings of gender confusion.

38. Even before A.S. "came out" to her grandmother, she had already begun to question whether she really felt like a boy or wanted to use her male name and male pronouns. But because the Sierra View community now viewed her as a boy, called her by a male name, and referred to her using male pronouns, A.S. felt like she was stuck in the new identity, which she inhabited for the remainder of her fifth-grade year. Her depression and anxiety worsened to the point where she wanted to transfer to a different school.

39. Over the rest of the spring semester and summer of 2022, A.S.'s feelings about being a boy continued to desist.

40. A.S. was slated to begin sixth grade at Marsh Junior High School ("Marsh"), another school within the District, for the 2022–2023 school year. In addition, C.S. was slated to begin third grade at Sierra View for the 2022–2023 school year.

41. By the beginning of the 2022–2023 school year, A.S. began identifying as a girl again. While she continues to identify as a girl, she is still in counseling for

her depression and anxiety.

Ms. Regino Tries to Persuade the District to Abandon the Policy

42. Soon after learning that the District had socially transitioned A.S. and kept it a secret from her, Ms. Regino had several telephone calls, in-person meetings, and email exchanges with District personnel in which she expressed her concerns about the District's actions.

43. In April of 2022, The District's Director of Elementary Education, Ted Sullivan, informed Ms. Regino that California law required schools to socially transition students without informing their parents unless the student authorizes them to do so.

44. In addition, Mr. Sullivan emailed Ms. Regino a link to an "FAQ" page on the California Department of Education ("DOE") website regarding Assembly Bill 1266 ("AB 1266"). *See* https://www.cde.ca.gov/re/di/eo/faqs.asp, last visited on January 5, 2023, attached hereto as Exhibit F, the entirety of which is expressly incorporated by reference under Rule 10(c) of the Federal Rules of Civil Procedure as if stated verbatim herein. AB 1266 was legislation, now codified at Cal. Ed. Code. § 221.5, designed to prohibit discrimination in schools based on gender identity.

45. On the FAQ page, the California DOE set forth guidance to "assist school districts with understanding and implementing policy changes related to AB 1266." *Id.* The guidance states that, when a transgender student "so chooses, [school] personnel *shall be required to address the student by a name and the pronouns consistent with the student's gender identity*, without the necessity of legal

documentation or a change to the student's official district record." *Id.* (emphasis added). It further provides that "schools must consult with [the] transgender student to determine who can or will be informed of the student's transgender status, *if anyone, including the student's family*." *Id.* (emphasis added). And it provides that "with rare exceptions, schools are required to respect the limitations that a student places on the disclosure of their transgender status, *including not sharing that information with the student's parents*." *Id.* (emphasis added).

46. Mr. Sullivan informed Ms. Regino that, based on this guidance, the Parental Secrecy Policy was required by California law.

47. The guidance, however, does not purport to have the force of law, nor does AB 1266 (or any other provision of California law) require schools to adopt the Parental Secrecy Policy. Instead, as relevant here, AB 1266 provides only that California public schools must allow students to "participate in sex-segregated school programs and activities . . . and use facilities consistent with his or her gender identity." *See* Calif. Educ. Code § 221.5(f). Moreover, even if California law required schools to adopt the Parental Secrecy Policy (and it does not), such law would be in violation of parents' fundamental right to direct the upbringing of their children.

48. As the 2021–2022 school year came to a close, Ms. Regino became concerned that (1) District employees at Marsh could attempt to socially transition A.S. without informing her, like they had done at Sierra View, and (2) District employees at Sierra View could also attempt to transition C.S. without her knowledge, as they had done with her sister. Disappointed by her exchange with Mr.

Sullivan, Ms. Regino reached out to other District administrators in an effort to convince them that the District should not follow the Parental Secrecy Policy any longer.

49. On or about May 5, 2022, Ms. Regino met with the District's Deputy Superintendent, Jay Marchant. Mr. Marchant, like Mr. Sullivan, informed Ms. Regino that the Parental Secrecy Policy was required by California law.

50. On or about August 9, 2022, Ms. Regino again met with Mr. Marchant, this time to seek to transfer her younger daughter, C.S., out of Sierra View and into a different school within the District, away from Ms. Robertson. On or about August 22, 2022, the District granted Ms. Regino's request, authorizing C.S. to transfer to Parkview, another school within the District.

51. Ms. Regino continued to press District administration for assurances that it would no longer enforce the Parental Secrecy Policy. On or about October 10, 2022, Ms. Regino met with the District's Superintendent, Kelly Staley, to discuss the issue. In that meeting, Ms. Staley, like Mr. Sullivan and Mr. Marchant, informed Ms. Regino that the Parental Secrecy Policy was required by California law.

52. On October 31, 2022, Ms. Regino emailed Superintendent Staley to reiterate her concerns with the Parental Secrecy Policy. On or about November 2, 2022, in response to Ms. Regino's follow-up email, Ms. Staley confirmed that the District would continue to apply the Parental Secrecy Policy at its schools, informing Ms. Regino that the District "must work within the confines of the law."

53. On information and belief, the District applies the Parental Secrecy

Policy, which includes all of terms listed on the California DOE's guidance document (Exhibit F), at all of its schools, including but not limited to Marsh and Parkview. While Ms. Regino does not have first-hand knowledge of these facts, these allegations are based on the facts that: (1) the California DOE asserts that the provisions of Exhibit F are required by AB 1266; (2) Mr. Sullivan emailed Ms. Regino a link to Exhibit F in response to her questions about the Policy; and (3) Ms. Staley, Mr. Marchant, and Mr. Sullivan all informed Ms. Regino that it was their belief that California public schools were required to enforce the Parental Secrecy Policy, a conclusion that would apply to all of the schools in the District. Based on this fact, the only reasonable conclusion is that the Parental Secrecy Policy, as set forth in Exhibit F, applies at all of the schools in the District, including but not limited to Marsh and Parkview, where Ms. Regino's daughters now attend.

The Threat to Ms. Regino's Rights is Ongoing

54. Ms. Regino respects her daughters' life choices and will be supportive of them no matter what those choices ultimately may be. Ms. Regino simply wants to be involved in her daughters' lives and with choices that have fundamental importance to them, such as choices regarding their gender identity. Because the District applies the Parental Secrecy Policy at the schools Ms. Regino's daughters attend, the Policy presents a real, imminent, and credible threat to her parental right to direct their upbringing insofar as it operates to keep decisions regarding her children's changed gender identities secret from her and allows such decisions to be made without her involvement. Given the quick onset of A.S.'s prior episode of gender

confusion, the continuing existence of stressors in her life, and her ongoing anxiety and depression, the reoccurrence of her prior feelings could happen at any time. Moreover, the same confusion could appear in C.S. at any time, especially considering the two girls' consanguinity and similar life experiences. Further, the District refused to disavow the Parental Secrecy Policy and, by definition, that Policy requires District employees to hide information from parents, thus disrupting one of the primary channels of parental knowledge about their children—namely, their schools. For this reason, Ms. Regino is subject to a real, imminent, and realistic danger that the Parental Secrecy Policy will (again) deprive her of the ability to be involved in the fundamental decisions in her children's lives.

55. So long as the Parental Secrecy Policy (or a similar policy) is in place, Ms. Regino faces the constant threat of constitutional harm.

CAUSES OF ACTION

COUNT ONE

Facial Challenge to Parental Secrecy Policy Under 42 U.S.C. § 1983 Substantive Due Process

56. Ms. Regino hereby incorporates by reference all other paragraphs of this Complaint as though fully set forth herein.

57. The Due Process Clause of the Fourteenth Amendment to the United States Constitution protects the fundamental rights of parents to direct the upbringing of their children; to make decisions concerning the care, custody, and control of their children; to direct the medical and mental health decision-making for their children; and to make private familial decisions regarding their children without undue interference by the state. These fundamental rights are deeply rooted

in our nation's history and tradition and implicit in the concept of ordered liberty.

58. On its face, the Parental Secrecy Policy violated in the past—and threatens to violate in the future—Ms. Regino's fundamental right to direct the upbringing of her children; to make decisions concerning the care, custody, and control of her children; to direct the medical and mental health decision-making for her children; and to make private familial decisions regarding her children without undue interference by the state.

59. The Parental Secrecy Policy violated—and threatens to violate—Ms. Regino's rights in the following ways, as explained in more detail in the Levine Affidavit (Exhibit A), the entirety of which is expressly incorporated by reference under Rule 10(c) of the Federal Rules of Civil Procedure as if stated verbatim herein:

a. The Parental Secrecy Policy authorizes children to make mature, consequential, private, and potentially life-altering decisions without parental knowledge or consent by excluding parents from the decision-making process on these matters;

b. The Parental Secrecy Policy takes from parents and arrogates to District personnel the authority to make these consequential, private, and potentially life-altering decisions for their children by excluding parents from the decision-making process and placing decision-making authority in District personnel;

c. The Parental Secrecy Policy takes from parents the authority to make these consequential, private, and potentially life-altering

decisions for their children by excluding parents from the decision-making process and placing decision-making authority in their children;

d. The Parental Secrecy Policy assumes that parents are not fit parents, capable of making decisions on behalf of their children, which both (1) violates the constitutionally mandated presumptions of fitness and affection unless proven otherwise and (2) impermissibly sows seeds of doubt in children's mind about whether their parents are acting in their best interests, thus creating a rift in the parent-child relationship;

e. The Parental Secrecy Policy usurps parents' responsibility as the ultimate decision-maker regarding their children's mental health and well-being, including but not limited to decisions related to their gender identity and expression, and assigns that responsibility to the District;

f. The Parental Secrecy Policy conceals important information from parents about their children's mental health and well-being, thus precluding them from taking actions that they would deem in their children's best interests if they were provided with the relevant information;

g. The Parental Secrecy Policy authorizes the District to engage in significant psychological treatment of children, in the form of

socially transitioning them to a new gender, without parents' knowledge or consent. When the District socially transitions a student, it is engaging in medical treatment of the child without parents' knowledge or consent;

h. The Parental Secrecy Policy results in the District providing substandard psychological treatment of children because parental involvement—and their deep knowledge of their children over their life course, family interactions, and extra-circular environment—is crucial in their diagnosis, assessment, and treatment;

i. The Parental Secrecy Policy results in the District providing substandard psychological treatment of children because it assumes that immediate and unqualified affirmation is the only permissible response to a child exhibiting gender confusion whereas, in reality, such a "one size fits all" approach to these issues is a blunt instrument that fails to account for the unique facts involved in each situation;

j. The Parental Secrecy Policy results in the District providing substandard psychological treatment of children because District personnel are not trained mental health practitioners in the field and thus are not qualified to provide students expressing gender confusion the care they need;

k. The Parental Secrecy Policy results in the District providing substandard psychological treatment of children because creating a situation where a child performs different gender identities and roles at home and school is inherently psychologically unhealthy for the child; and

l. The Parental Secrecy Policy results in the District providing unconsented-to psychological treatment because: (1) children are cognitively incapable of giving informed consent to life-altering psychological interventions like social transitioning and the more-drastic gender-affirming care that is likely to follow; (2) District personnel do not have sufficient knowledge of the complexities and risks inherent in the field to provide students sufficient information that they could provide informed consent even if they were cognitively capable of doing so; and (3) District personnel do not have sufficient knowledge of the complexities and risks inherent in the field to themselves evaluate whether social transitioning is appropriate and ethical treatment.

60. The Parental Secrecy Policy is not narrowly tailored to any compelling governmental purpose, does not further any important government purpose, and is not supported by any rational basis.

61. Ms. Regino has no adequate remedy at law for these deprivations and will suffer serious and irreparable harm to her constitutional rights unless

Defendants are enjoined as set forth herein.

62. Ms. Regino is entitled to declaratory relief and preliminary and permanent injunctive relief invalidating and restraining Defendants from their ongoing violations of her constitutional rights as set forth herein.

COUNT TWO
As-Applied Challenge to Parental Secrecy Policy
Under 42 U.S.C. § 1983
Substantive Due Process

63. Ms. Regino hereby incorporates by reference all other paragraphs of this Complaint as though fully set forth herein, including but not limited to the Levine Affidavit.

64. Defendants' application of the Parental Secrecy Policy to Ms. Regino also violated in the past—and threatens to violate in the future—her parental rights for all of the ways previously set forth herein, including but not limited to the ways set forth in Paragraph 59, including all subparts.

65. The District's actions toward Ms. Regino as alleged herein are not narrowly tailored to any compelling governmental purpose, do not further any important government purpose, and are not supported by any rational basis.

66. Ms. Regino has no adequate remedy at law for these deprivations and will suffer serious and irreparable harm to her constitutional rights unless Defendants are enjoined as set forth herein.

67. Ms. Regino is entitled to declaratory relief and preliminary and permanent injunctive relief invalidating and restraining Defendants from their

ongoing violations of her constitutional rights as set forth herein.

COUNT THREE
Facial Challenge to Parental Secrecy Policy
Under 42 U.S.C. § 1983
Procedural Due Process

68. Ms. Regino hereby incorporates by reference all other paragraphs of this Complaint as though fully set forth herein, including but not limited to the Levine Affidavit.

69. On its face, the Parental Secrecy Policy violated in the past—and threatens to violate in the future—Ms. Regino's fundamental right to direct the upbringing of her children; to make decisions concerning the care, custody, and control of her children; to direct the medical and mental health decision-making for her children; and to make private familial decisions regarding her children without undue interference by the state without providing adequate procedural safeguards, including a thorough investigation, notice, and an opportunity to be heard with respect to the deprivation of parents' parental rights.

70. Ms. Regino has no adequate remedy at law for these deprivations and will suffer serious and irreparable harm to her constitutional rights unless Defendants are enjoined as set forth herein.

71. Ms. Regino is entitled to declaratory relief and preliminary and permanent injunctive relief invalidating and restraining Defendants from their ongoing violations of her constitutional rights as set forth herein.

COUNT FOUR
As-Applied Challenge to Parental Secrecy Policy
Under 42 U.S.C. § 1983
Procedural Due Process

72. Ms. Regino hereby incorporates by reference all other paragraphs of this Complaint as though fully set forth herein, including but not limited to the Levine Affidavit.

73. As applied, the Parental Secrecy Policy violated in the past—and threatens to violate in the future—Ms. Regino's fundamental right to direct the upbringing of her children; to make decisions concerning the care, custody, and control of her children; to direct the medical and mental health decision-making for her children; and to make private familial decisions regarding her children without undue interference by the state without providing adequate procedural safeguards, including a thorough investigation, notice, and an opportunity to be heard with regard to the deprivation of her parental rights.

74. Ms. Regino has no adequate remedy at law for these deprivations and will suffer serious and irreparable harm to her constitutional rights unless Defendants are enjoined as set forth herein.

75. Ms. Regino is entitled to declaratory relief and preliminary and permanent injunctive relief invalidating and restraining Defendants from their ongoing violations of her constitutional rights as set forth herein

PRAYER FOR RELIEF

WHEREFORE, Plaintiff Aurora Regino requests the following relief:

1. A declaration that the District's Parental Secrecy Policy is both facially

invalid and invalid as applied to her under the Fourteenth Amendment to the United States Constitution;

2. A preliminary and permanent injunction preventing Defendants from continuing to implement the Parental Secrecy Policy, during the pendency of this litigation and at all times in the future, both facially and as applied to Ms. Regino;

3. Costs and attorney's fees pursuant to 42 U.S.C. § 1988;

4. A trial by jury on all claims for which Plaintiff has such a right; and

5. Such further relief that the Court deems just and proper.

Dated: January 6, 2023

Respectfully submitted,

By: */s/Harmeet K. Dhillon*

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Attorneys for Plaintiff
**Pro Hac Vice* Motions Forthcoming

VERIFICATION

I, AURORA REGINO, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am over the age of eighteen years old, I am competent to make this verification, and have personal knowledge of the matters set forth herein.

2. I have reviewed the Complaint to be filed on my behalf in this matter.

3. I have personal knowledge of the factual allegations in paragraphs 1–2, 3 (first sentence), 4–23, 28, 35 (second sentence), 36–37, and 40–55 of the Complaint. Those allegations are true and correct to the best of my knowledge.

4. My daughter, A.S., informed me of the factual allegations contained in paragraphs 3 (all sentences other than first sentence), 24–27, 29–35 (first sentence), and 38–39 of the Complaint. Based on my conversations with A.S., and her reputation and character of truthfulness, which I know based on my interactions with her as her mother, I believe these allegations to be true and correct to the best of my knowledge.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge.

Executed on January 5, 2022

Aurora Regino

AURORA REGINO

VERIFICATION

I, A.S., pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am twelve years old. I have personal knowledge of the matters set forth herein.

2. I have reviewed the Complaint to be filed on behalf of my mother in this matter.

3. I have personal knowledge of the factual allegations in paragraphs 3 (all sentences other than first sentence), 24–27, 29–35 (first sentence), and 38–39 of the Complaint. I believe these allegations to be true and correct to the best of my knowledge.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge.

Executed on January 5, 2022

A.S.

A.S.

EXHIBIT A

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Attorneys for Plaintiff
**Pro Hac Vice* Motions Forthcoming

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

AURORA REGINO,

Plaintiff,

v.

SUPERINTENDENT KELLY STALEY, in her official capacity, CAITLIN DALBY, in her official capacity, REBECCA KONKIN, in her official capacity, TOM LANDO, in his official capacity, EILEEN ROBINSON, in her official capacity, MATT TENNIS, in his official capacity,

Defendants.

Case No._____

EXPERT AFFIDAVIT OF
DR. STEPHEN B. LEVINE, MD

TABLE OF CONTENTS

STATE OF OHIO)
) SS
CUYAHOGA COUNTY)

Stephen B. Levine, being duly sworn, states as follows:

I. CREDENTIALS & SUMMARY

1. I am Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine, and I maintain an active private clinical practice. I received my MD from Case Western Reserve University in 1967, and I completed a psychiatric residency at the University Hospitals of Cleveland in 1973. I became an Assistant Professor of Psychiatry at Case Western in 1973, became a Full Professor in 1985, and in 2021 was honored to be inducted into the Department of Psychiatry's "Hall of Fame."

2. Since July 1973, my specialties have included psychological problems and conditions relating to individuals' sexuality and sexual relations, therapies for sexual problems, and the relationship between love, intimate relationships, and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research. I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental*

Health Professionals. In addition to five previously solo-authored books for professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book has a chapter titled "The Gender Revolution."

4. In total I have authored or co-authored over 180 journal articles and book chapters, twenty-five of which deal with the issue of gender dysphoria.

5. I first encountered a patient suffering from what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic, and I have served as Co-Director of that clinic since that time. Across the years, our Clinic evaluated and treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric caregiver for several dozen of our patients and supervisor of the work of other therapists. In 1993 the Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-director in my current practice setting. I was an early member of the Harry Benjamin International Gender Dysphoria Association (later known as the World Professional Association for Transgender Health (WPATH)) and served as the Chairman of the committee that developed the 5th version of its Standards of Care published in 1999.

6. In the course of my five decades of practice treating patients who suffered from gender dysphoria, I have recommended or prescribed or supported

social transition, cross-sex hormones, and surgery for particular patients, but only after extensive diagnostic and psychotherapeutic work. The vast majority of these patients were older adolescents and adults.

7. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts asked me to serve as an independent, court-appointed expert in a litigation involving the treatment of a transgender inmate within the Massachusetts prison system. In that litigation, the U.S. Court of Appeals for the First Circuit in a 2014 (En Banc) opinion cited and relied on my expert testimony. I have been retained by the Massachusetts Department of Corrections as a consultant on the treatment of transgender inmates since 2007.

8. In 2019, I was qualified as an expert and testified concerning the diagnosis, understanding, developmental paths and outcomes, and therapeutic treatment of transgenderism and gender dysphoria, particularly as it relates to children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-09887-S, 255th Judicial District, Dallas County, TX (the "*Younger* litigation"). In 2019, I provided written expert testimony in the landmark case in the United Kingdom called *Bell v. The Tavistock and Portman NHS Foundation Trust*. I have further listed the cases in which, during the previous 4 years, I testified as an expert at trial or by deposition in my curriculum vitae.

9. I am regularly requested to speak on the topic of gender dysphoria and have given countless presentations to academic conferences and Departments of Psychiatry around the country. In May 2022, I organized and co-presented a symposium on the management of adolescent-onset transgender identity at American Psychiatric Association's Annual Meeting.

10. A fuller review of my professional experience, publications, and awards is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

11. I am being compensated for my time spent in connection with this case at a rate of $400.00 per hour / $500.00 per hour for work done on testimony, including but not limited to testifying itself.

12. A summary of the key points that I explain in this report is as follows:

a. Sex as defined by biology and reproductive function is clear, binary, and cannot be changed. While hormonal and surgical procedures may enable some individuals to "pass" as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex. (Section II.A.)

b. The diagnosis of "gender dysphoria" is associated with a diverse array of conditions, with widely differing pathways and characteristics

depending on age of onset, biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.)

c. Among practitioners in the field, there are currently widely varying views concerning both the causal influences on and the appropriate therapeutic response to gender dysphoria in children or adolescents. There are no generally accepted "standards of care" either internationally or within the United States. Existing studies do not provide a basis for a scientific conclusion as to which therapeutic response results in the best long-term outcomes for affected individuals. (Section III.).

d. Transgender identity is not biologically determined. Rather, gender dysphoria is a psychiatric condition that cannot be identified by any biological test or measurement. (Sections IV.A.). At best, it may be biologically influenced through temperament.

e. The large majority of children who are diagnosed with gender dysphoria "desist"—that is, their gender dysphoria does not persist—by puberty or adulthood. Desistance is also increasingly observed among teens and young adults who have experienced "rapid onset gender dysphoria" —

first manifesting gender dysphoria during or shortly after adolescence. (Section IV.B, IV.C.)

f. "Social transition"—the active affirmation of transgender identity in young children—usually refers to five changes: 1. renaming the child with a name associated with the opposite gender; 2. using the pronouns of the aspired to gender; 3. encouraging the use of opposite sex bathrooms; 4. dressing the child as if it were a member of the opposite sex; and 5. using a hair style that is associated with the opposite sex These five approaches singly or in combination are a powerful psychotherapeutic intervention that substantially reduce the number of children "desisting" from transgender identity. Therefore, the profound implications of future "affirmative" treatment—which include taking puberty blockers, cross-sex hormones, and ultimate surgeries—must be taken into account where social transition of a child is being considered. (Section V.A, V.B.)

g. Administration of puberty blockers is not a benign "pause" of puberty, but rather a powerful medical and psychotherapeutic intervention that almost invariably leads to persistence in a transgender identity and, ultimately, to the administration of cross-sex hormones. (Section V.C.)

h. The knowledge base concerning the "affirmative" treatment of gender dysphoria available today has very low scientific quality with many long-term implications remaining unknown. (Section VI.A.)

i. There are no studies that show that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes, as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population. This is true before and after transition, hormones, and surgery. (Section VI.B., VI.C.)

j. In light of what is known and not known about the impact of affirmation on the incidence of suicide, suicidal ideation, and other indicators of mental and physical health, it is scientifically baseless, and therefore unethical, to assert that a child or adolescent who express an interest in a transgender identity will kill him- or herself unless adults and peers affirm that child in a transgender identity. (Section VII.)

k. Hormonal interventions to treat gender dysphoria are experimental in nature and have not been shown to be safe in the long run. These interventions put an individual at risk of life-long harms. These include

diverse physical-health risks; sterilization; impaired sexual response; the need for lifelong medical monitoring, and shortened life expectancies. Moreover, hormonal treatment very often leads to surgical interventions which have significant complications. Psychiatric complications include the alienation of family; impaired romantic relationships; and elevated risks of depression, anxiety, substance abuse, and suicide. (Section VIII.)

l. When dealing with a minor child or adolescent with a transgender identity, parental (or guardian)[1] involvement is necessary to obtain an accurate, thorough, and relevant developmental history. Not only does this increase the chances of a comprehensive list of diagnoses, but it guides effective psychotherapeutic treatment planning and execution. (Section IX.A, IX.B.)

m. It is psychologically unhealthy for a minor to live radically different identities at home and at school, and to conceal what he or she perceives to be his or her current gender identity from parents. This typically creates an adversarial relationship between the minor and the parents, distorting the fact that the welfare of the minor is their joint goal. (Section IX.C.)

[1] Unless the context indicates otherwise, my use of the term "parents" throughout this document includes "guardians," whether formal or informal.

n. Schools are not equipped to guide minors through the difficult and life-altering decisions surrounding social transition to support a transgender identity given the complex medical ethics issues that arise. (Section IX.D.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of the binary sexes

13. Biological sex is very well defined in all biological sciences including medicine. It is pervasively important in human development throughout the lifecycle.

14. Sex is not "assigned at birth" by humans visualizing the genitals of a newborn; sex determination is not an imprecise process. Rather, it is clear, binary, and determined at conception. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. Sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. A publication of the federal government's National Institute of Health accurately summarizes the scientific facts:

> "Sex is a biological classification, encoded in our DNA. Males have XY chromosomes, and females have XX chromosomes. Sex makes us male or female. Every cell in your body has a sex—making up tissues and organs, like your skin, brain, heart, and stomach. Each cell is either male or female depending on whether you are a man or a woman." (NIH 2022.)

15. The binary nature of biological sex is so fundamental and wide-ranging in its effects on human (and mammal) development and physiology that since 2014 the NIH has required all funded research on humans or vertebrate animals to include "sex as a biological variable" and give "adequate consideration of both sexes in experiments." (NIH 2015). In 2021, the Endocrine Society issued a position paper elaborating on the application of the NIH requirement. The Endocrine Society correctly stated that "Sex is a biological concept . . . all mammals have 2 distinct sexes;" that "biological sex is . . . a fundamental source of intraspecies variation in anatomy and physiology;" and that "In mammals, numerous sexual traits (gonads, genitalia, etc.) that typically differ in males and females are tightly linked to each other because one characteristic leads to sex differences in other traits." (Bhargava et al. 2021 at 221, 229.)

16. The Endocrine Society has emphasized that "The terms sex and gender should not be used interchangeably," and noted that even in the case of those "rare" individuals who suffer from some defect such that they "possess a combination of male- and female-typical characteristics, those clusters of traits are sufficient to classify most individuals as either biologically male or female." They concluded, "Sex is an essential part of vertebrate biology, but gender is a human phenomenon. Sex often influences gender, but gender cannot influence sex." (Bhargava et al. 2021 at 220-221, 228.)

17. As these statements and the NIH requirement suggest, biological sex pervasively influences human anatomy, development and physiology. This includes, of course, the development of the brain, in which many sexually dimorphic characteristics have now been identified. In particular, the Endocrine Society and countless other researchers have determined that human brains undergo particular sex-specific developmental stages during puberty. This predictable developmental process is a genetically controlled coordinated endocrine response that begins with pituitary influences leading to increases in circulating sex hormones. (Bhargava et al. 2021 at 225, 229; Blakemore et al. 2010 at 926-927, 929; NIH 2001.)

18. Humans have viewed themselves in terms of binary sexes since the earliest historical records. Recognizing a concept of "gender identity" as something distinct from sex is a rather recent innovation whose earliest manifestations likely began in the late 1940s. Its usage became common in medicine in the 1980s and subsequently in the larger culture. Definitions of gender have been evolving and remain individual-centric and subjective. In a statement on "Gender and Health," the World Health Organization defines "gender" as "the characteristics of women, men, girls and boys that are socially constructed" and that "var[y] from society to society and can change over time," and "gender identity" as referring to "a person's deeply felt, internal and individual experience of gender." (WHO Gender

and Health.) As these definitions indicate, a person's "felt" "experience of gender" is inextricably bound up with and affected by societal gender roles and stereotypes—or, more precisely, by the affected individual's *perception* of societal gender roles and stereotypes and their personal idiosyncratic meanings. Typically, young trans-identifying persons also have subtly different, often idiosyncratic, reactions to societal gender roles and stereotypes.

19. The self-perceived gender of a child begins to develop along with the early stages of identity formation, influenced in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show awareness of the two possibilities. As acceptance of the designated gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Is it a product of the quality of early life attachments to caregivers? Does it stem from trauma-based rejection of maleness or femaleness, and if so, flowing from what trauma? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition (autism)? The answers to these relevant questions are not scientifically known but are not likely

to be the same for every trans-identified child, adolescent, or adult. Ideally, clinicians try to answer these questions as best as they can when reviewing a child's development.

20. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop postnatally, culminating in the dramatic maturation of the primary and secondary sex characteristics with puberty. These include differences in hormone levels, height, weight, bone mass, shape, musculature, strength, body fat levels and distribution, and hair patterns, as well as physiological differences such as menstruation, ejaculation, and lung capacity. These are genetically programmed biological consequences of sex. These are the predictable consequences of the determination of sex that occurred when the ovum was fertilized by the sperm. Among the usual consequences of sex is the continuing consolidation process of a congruent gender identity during and after puberty.

21. Despite the increasing ability of hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes, including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally defined sex. For instance, the XX (genetically female) individual who takes testosterone to

stimulate certain male secondary sex characteristics will nevertheless remain unable to produce sperm and father children.

22. Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a complete man" or "a complete woman," this is not biologically attainable. (Levine 2018 at 6; Levine 2016 at 238.) It is possible for some adolescents and adults to pass unnoticed—that is, to be perceived by most individuals as a member of the gender that they aspire to be—but with limitations, costs, and risks, as I detail later.

B. Definition and diagnosis of gender dysphoria

23. Specialists have used a variety of terms over time, with somewhat shifting definitions, to identify and speak about a distressing incongruence between an individual's genetically determined sex and the gender with which they identify or to which they aspire. Today's American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5-TR") employs the term Gender Dysphoria and defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

24. There are at least five distinct pathways to gender dysphoria: early childhood onset; onset near or after puberty with no prior behavioral cross gender patterns; onset after defining oneself as gay for several or more years and participating in a homosexual lifestyle; adult onset after years of heterosexual

transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity. (Levine 2021.) The early childhood onset pathway and the more recently observed onset around puberty pathway are most relevant to this matter.

25. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients. (Zucker 2018 at 10.) The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

26. The criteria used in DSM-5-TR to identify Gender Dysphoria include a number of signs of discomfort with one's natal sex and vary somewhat depending on the age of the patient, but in all cases require "clinically significant distress or impairment in . . . important areas of functioning" such as social, school, or occupational settings. The symptoms must persist for at least six months. DSM-5-TR recognizes a person can have a transgender identity without distress or impairment of function and therefore not qualify for a diagnosis of gender dysphoria. Moreover, the distress and impairment criteria may fluctuate over time.

27. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—

possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of what men and women can be. (Levine 2017 at 7.) A young child's—or even an adolescent's—understanding of this topic is quite limited. Nor can they grasp what it may mean for their future to be sterile. These children and adolescents consider themselves to be relatively unique; they do not realize that discomfort with the body and perceived social role is neither rare nor new to civilization. What is new is that such discomfort is thought to indicate that they must be a trans person.

C. Impact of gender dysphoria on minority and vulnerable groups

28. Given that, as I discuss later, a diagnosis of gender dysphoria is now frequently putting even young children on a pathway to irreversible physical changes and sterilization by young adulthood, it should be of serious concern to all practitioners that minority and vulnerable groups are receiving this diagnosis at disproportionately high rates. These include: children of color (Rider et al. 2018), children with mental developmental disabilities (Reisner et al. 2015), children on the autistic spectrum (at a rate more than 7x the general population) (Shumer et al. 2016a; van der Miesen et al. 2018), children with ADHD (Becerra-Culqui et al. 2018), children residing in foster care homes, adopted children (at a rate more than

3x the general population) (Shumer et al. 2017), victims of childhood sexual or physical abuse or other "adverse childhood events" (Thoma 2021 et al.; Newcomb et al. 2020; Kozlowska et al. 2021), children with a prior history of psychiatric illness (Edwards-Leeper et al. 2017; Kaltiala-Heino et al. 2015; Littman 2018), and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys) (Rider et al. 2018 at 4).

29. Furthermore, in my own practice, I have seen how families facing hardships such as financial difficulties, family conflict, imprisonment, and health issues are unable to thoroughly consider the full implications of gender transition and affirmative care. Thus, these already vulnerable minors are particularly susceptible to the possibility of life-changing interventions that can end in sterilization.

D. Three competing conceptual models of gender dysphoria and transgender identity

30. Discussions about appropriate responses by mental health professionals ("MHPs") to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and advocates (or a single speaker at different times) view transgenderism through at least three very different paradigms, often without being aware of, or at least without acknowledging, the distinctions.

31. Gender dysphoria is **conceptualized and described by some professionals and laypersons as though it were a serious, physical medical illness that causes suffering**, comparable to diseases that are curable before it spreads, such as melanoma or sepsis. Within this paradigm, whatever is causing distress associated with gender dysphoria—whether secondary sex characteristics such as facial hair, nose and jaw shape, presence or absence of breasts, or the primary anatomical sex organs of testes, ovaries, penis, or vagina—should be removed to alleviate the illness. The promise of these interventions is no less than the cure of the gender dysphoria.

32. It should be noted that gender dysphoria is a psychiatric, not a medical, diagnosis. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and has not been specified in medical diagnostic manuals. Notably, gender dysphoria is the only psychiatric condition to be routinely treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine 2016 at 240.)

33. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that may have been first manifested as a failure to establish a comfortable conventional sense of self in early childhood. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans persons' lives are not exceptions to

this axiom. (Levine 2016 at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address causes of the basic problem of the deeply uncomfortable self or a sense of self impaired by later adversity or abuse. The purpose is to ameliorate suffering when the underlying problem cannot be solved. MHPs first work with the patient and family to learn about the events and processes that may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play and adolescents work out their issues by adopting various interests and identity labels.

34. There is evidence among adolescents that peer social influences through "friend groups" (Littman 2018) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity. Responsible MHPs will want to probe these potential influences to better understand what is truly deeply tied to the psychology of the patient, and what may instead be being "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

35. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all of the numerous aspects of an

individual's identity evolve—often markedly—across the individual's lifetime (Levine, 2021). This includes gender identity. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and eternally present in an unchanging manner. As I review later, however, this assertion is not supported by science.[2]

36. The third paradigm through which gender dysphoria is alternatively conceptualized is from **a sexual minority rights perspective**. Under this paradigm, any response other than medical and societal affirmation and implementation of a patient's claim to "be" the opposite gender is a violation of the individual's civil right to self-expression. Any effort to ask "why" questions about the patient's condition, or to address underlying causes, is viewed as a violation of autonomy and civil rights. In the last few years, this paradigm has been successful in influencing public policy and the education of pediatricians, endocrinologists, and many MHPs. Obviously, however, this is not a medical or psychiatric perspective. Unfortunately, it appears to be the most powerful perspective that exists in the public, non-scientific debate. More worrisome is the fact that this perspective profoundly influences thinking within many elements of the medical profession, giving precedence to political ideology over scientific data.

[2] Even the advocacy organization The Human Rights Campaign asserts that a person can have "a fluid or unfixed gender identity." https://www.hrc.org/resources/glossary-of-terms.

E. Four competing models of therapy

37. Few would disagree that the human psyche is complex. Few would disagree that children's and adolescents' developmental pathways typically have surprising twists and turns. The complexity and unpredictability of childhood and adolescent development equally applies to trans-identifying youth. Because of the absence of placebo-controlled clinical trials and the failure to generate adequate follow-up, substantial disagreements among professionals about the causes of trans identities and their best treatments exist. Even lacking placebo-controlled trials, these current disagreements might have been minimized if trans treated persons were carefully followed up to determine medium- (2-3 years) and long term (5-10 years) medical, social, vocational, and psychological outcomes. They have not been. When we add to this to the very different current paradigms for understanding transgender phenomena, it is not scientifically surprising that disagreements are sharply drawn between those who have faith that the outcomes are generally quite positive and those who are skeptical but uncertain. It is with this in mind that I summarize below the leading approaches and offer certain observations and opinions concerning them.

(1) The "watchful waiting" therapy model

38. In Section V.A below I review the uniform finding of eleven follow-up studies that the large majority of children who present with gender dysphoria

will desist from desiring a transgender identity by adulthood if left untreated by social transition approaches.

39. When a pre-adolescent child presents with gender dysphoria, a "watchful waiting" approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. Watchful waiting has two versions:

a. Treating any other psychological co-morbidities—that is, other mental illnesses as defined by DSM-5-TR (separation anxiety disorder, attention deficit hyperactivity disorder, autism spectrum disorder, learning disorders, obsessive compulsive disorder, etc), or subthreshold for diagnosis but behavioral problems that the child may exhibit (school avoidance, bedwetting, inability to make friends, aggression/defiance) without a focus on gender (**model #1**); and

b. No treatment at all for anything but a regular follow-up appointment. This might be labeled a "hands off" approach **(model #2**).

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3)

40. One of the foundational principles of psychotherapy has long been to work with a patient to identify the causes of observed psychological distress and then to address those causes as a means of alleviating the distress. The National Institute of Mental Health has promulgated the idea that 75% of adult

psychopathology has its origins in childhood experience. Many experienced practitioners in the field of gender dysphoria, including myself, believe that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient's life are the determinants of the patient's repudiation of his or her natal sex. (Levine 2017 at 8; Levine 2021.) I and others (Gender Exploratory Therapy Association (2022), *A Clinical Guide for Therapists Working with Gender-Questioning Youth* (Version 1)) have reported success in alleviating distress in this way for some patients, whether the patient's sense of discomfort or incongruence with his or her natal sex entirely disappeared or not. Relieving accompanying psychological co-morbidities leaves the patient freer to consider the pros and cons of transition as he or she matures.

41. Among other things, the psychotherapist who is applying traditional methods of psychotherapy may help—for example—the male patient appreciate the wide range of masculine emotional and behavioral patterns as he grows older. He may discuss with his patient, for example, that one does not have to become a "woman" in order to be kind, compassionate, caring, noncompetitive, to love the arts, and to be devoted to others' feelings and needs. (Levine 2017 at 7.) Because he is interested in classical music and not sports and feels unready to be interested in partner sexual behaviors does not mean he must be a woman. Many biologically

male trans individuals, from childhood to older ages, speak of their perceptions of femaleness as enabling them to discuss their feelings openly, whereas they perceive boys and men to be constrained from emotional expression within the family and larger culture, and to be aggressive. Men, of course, can be emotionally expressive, just as they can wear pink. Converse examples can be given for girls and women. These types of ideas regularly arise during psychotherapies.

42. As I note above, many gender-nonconforming children and adolescents in recent years derive from minority and vulnerable groups who have reasons to feel isolated and have an uncomfortable sense of self. A trans identity may be a hopeful attempt to redefine the self in a manner that increases their comfort and decreases their anxiety. The clinician who uses traditional methods of psychotherapy may not focus on their gender identity, but instead work to help them to address the actual sources of their discomfort. Success in this effort may remove or reduce the desire for a redefined identity. This often involves a focus on disruptions in their attachment to parents in vulnerable children, for instance, those in the foster care system.

43. Because "watchful waiting" can include treatment of accompanying psychological co-morbidities, and the psychotherapist who hopes to relieve gender dysphoria may focus on potentially causal sources of psychological distress rather

than on the gender dysphoria itself, there is no sharp line between "watchful waiting" and the psychotherapy model in the case of prepubescent children.

44. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women. On the other hand, anecdotal evidence of such outcomes does exist, and I and other clinicians have witnessed reinvestment in the patient's biological sex in some individual patients who are undergoing psychotherapy. I have published a paper on a patient who sought my therapeutic assistance to reclaim his male gender identity after 30 years living as a woman and is in fact living as a man today. (Levine 2019.)

45. I have seen children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist. In conducting parent guidance, I have seen an adolescent desist in response to his parents' calmness and their comments about the normality of adolescent exploration of various forms of sexual identity. And as a supervisor, I have guided an experienced psychotherapist in her work with trans-identified adolescents and young adults who have desisted and returned to social roles consistent with their biological sex. There are now a series of articles and at least one major book on the psychological treatment of adolescents. (D'Angelo et al. 2021 at 7-16; Evans &

Evans 2021; Marchiano 2021; Churcher-Clarke & Spiliadis, 2019; Parkinson, 2014; Withers, 2020.)

(3) The affirmation therapy model (model #4)

46. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child or adolescent regardless of the therapy model, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with transgender identity. They argue that the child should be comprehensively re-socialized in grade school in their aspired-to gender. These advocates treat any question about the causes of the child's transgender identification as inappropriate. They may not recognize the child's ambivalence. They assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

47. Some advocates assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. This claim is simply not supported by the clinical data we have available to us. Indeed, available long-term

data contradicts this claim. I address physical and mental health outcomes in Section VII below, and suicide in Section VIII below.

48. I do not know with certainty what proportion of practitioners are using which model. On one hand, Dr. James Cantor may have been correct when he wrote that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty." (Cantor 2019 at 1). On the other hand, this may be increasingly incorrect as applied to children and adolescents in the United States. Most parents and most parent groups report (Gender Exploratory Therapy Association (2022), *A Clinical Guide for Therapists Working with Gender-Questioning Youth* (Version 1)) how difficult it is to find a therapist who is non-affirmative in their communities. This is consistent with the proliferation of gender affirmative clinics in the last several years. A journalist reported to me in December 2022 that the latest count was 177. Just several years ago, the quoted number was 70. It must be that these clinic personnel believe that science has already established that affirmative care is superior to all other models of care in facilitating happy, productive, fulfilling lives. They are not well-informed.

49. In my opinion, in the case of young children, prompt and thorough affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Instead of science, this

approach is currently being reinforced by an echo-chamber of approval from other like-minded child-oriented professionals who do not sufficiently consider the known negative medical and psychiatric outcomes of trans adults. Rather than recommend social transition in grade school, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with by each of them. As I discuss further in Section III.D below, it should be noted that the distinct trend in western Europe is to make psychotherapy, not affirmation, the first approach to Gender Dysphoria in children and adolescents. Many advocates in the United States seem to be still defending immediate affirmative care, rejecting or being unaware of the evidence reviews that changed policies in several European countries. The loud pervasive voice of advocacy of affirmation drowns out the concerns of many pediatric specialists who do not support affirmation as the "best practice."

50. Since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

III. THERE IS NO CONSENSUS OR AGREED "STANDARD OF CARE" CONCERNING THERAPEUTIC APPROACHES TO CHILD OR ADOLESCENT GENDER DYSPHORIA.

51. As I review in separate sections later, there is far too little firm clinical evidence in this field to permit any evidence-based standard of care. Given the lack of scientific evidence, it is neither surprising nor improper that—as I detailed in Section II—there is a diversity of views among practitioners as to the best therapeutic response for the child, adolescent, or young adult who suffers from gender dysphoria.

52. Reviewing the state of opinion and practice in 2021, the Royal Australian and New Zealand College of Psychiatrists observed that "There are polarized views and mixed evidence regarding treatment options for people presenting with gender identity concerns, especially children and young people." (RANZCP, 2021.) Similarly, a few years earlier prominent Dutch researchers noted: "[T]here is currently no general consensus about the best approach to dealing with the (uncertain) future development of children with GD and making decisions that may influence the function and/or development of the child — such as social transition." (Ristori & Steensma 2016 at 18.)[3] In this Section, I comment on some of the more important areas of disagreement within the field.

[3] *See also* Zucker 2020 which questions the merit of social transition as a first-line treatment.

A. Experts and organizations disagree as to whether "distress" is a necessary element for diagnoses that justifies treatment for gender identity issues.

53. As outlined in Section II.B above, "clinically significant distress" is one of the criteria used in DSM-5-TR to identify gender dysphoria. This indicates a heightened level of distress that rises beyond a threshold level of social awkwardness or discomfort with the changing body. It is known that many trans-identified youth with incongruence between their sexed bodies and their gender identity choose not to take hormones; their incongruence is quite tolerable as they further clarify their sexual identity elements. This population raises the questions of what distress is being measured when DSM-5-TR criteria are met, and what else might be done about it.

54. There is no "clinically significant distress" requirement in World Health Organization's International Classification of Diseases (ICD-11) criteria for gender incongruence, which rather indicates "a marked and persistent incongruence between an individual´s experienced gender and the assigned sex." (World Health Organization 2019.) Nor is there a duration criterion or an impairment criterion. If one has gender incongruence affirmative care can be indicated.

55. Therefore, even between these two committee-based authorities, there is a significant disagreement as to what constitutes a gender condition justifying

life-changing interventions. To my knowledge, some American gender clinics and practitioners are essentially operating under the ICD-11 criteria rather than the APA's DSM-5-TR criteria, prescribing transition for children, hormonal interventions for slightly older children, and different hormones for adolescents who assert a desire for a transgender identity whether or not they are exhibiting "clinically significant distress." Others adhere to the DSM-5-TR diagnostic standard.

56. Even from within one "school of thought," it is not responsible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues, such as a statement that all such persons should be socially transitioned. There is no single pathway to the development of a trans identity and no reasonably uniform short- or long-term outcome of medically treating it. As individuals grow physically, mature psychologically, and experience or fail to experience satisfying romantic relationships, their life course depends on their differing psychological, social, familial, and life experiences. There should be no trust in assertions that trans identified youth must be treated in a particular manner to avoid harm for three reasons. First, there is no systematic data on the nature of, and the rate of harms of either affirmative treatment, no treatment, or psychological only treatment. Second, as in other youthful psychiatric and other challenges, outcomes

vary. Third, many psychological, social, and experiential forces outside of medical professions' knowledge shape outcomes.

B. Opinions and practices vary widely about the utilization of social transition for children and adolescents.

57. WPATH— which explicitly views itself as not merely a scientific organization, but also as an advocacy and policy shaping organization[4]— does not take a position in its 7th version concerning whether or when social transition may be appropriate for pre-pubertal children. Its 7th Version states that the question of social transition for children is a "controversial issue" and calls for mental health professionals to support families in what it describes as "difficult decisions" concerning social transition. In its 8th version, the word "controversial" no longer appears; rather, parents and doctors are urged to be prudent about the advantages and disadvantages of gender transition of prepubertal children. Although the version 8 does not explicitly say so, the controversy within pediatric medicine persists, if not in heightened form.

58. Dr. Erica Anderson is a prominent practitioner in this area who identifies as a transgender woman, was the first transgender president of the United States Professional Association for Transgender Health (USPATH), and is a former board member of WPATH. Dr. Anderson recently resigned from those

[4] Levine 2016 at 240.

organizations and has condemned automatic approval of transition upon the request of a child or adolescent, noting that "adolescents . . . are notoriously susceptible to peer influence," that transition "doesn't cure depression, doesn't cure anxiety disorders, doesn't cure autism-spectrum disorder, doesn't cure ADHD," and instead that "a comprehensive biopsychosocial evaluation" should proceed allowing a child to transition. (Davis 2022.) And as I have explained previously, my own view based on 50 years of experience in this area favors strong caution before approving life-altering interventions such as social transition, puberty blockers, or cross-sex hormones. A "one size fits all" approach—such as one that insists on social transitioning all trans identifying children—necessarily does not take account of, nor resolve, the broader issues facing the youth in question.

C. Opinions and practices differ widely with respect to the proper role of psychological counseling before, as part of, or after a diagnosis of gender dysphoria.

59. In Version 7 of its self-proclaimed "Standards of Care" document,[5] released in 2012, WPATH downgraded the role of counseling or psychotherapy, and the organization no longer sees psychotherapy without transition and hormonal interventions as a potential path to eliminate gender dysphoria by enabling a

[5] It should be noted that WPATH's "Standards of Care" document is not the product of a strictly scientific organization and is by no means accepted by all, or even most, practitioners as setting out best practices. *See* Levine 2016 at 240.

patient to return to or achieve comfort with the gender identity aligned with his or her biology.

60. Around the world, many prominent voices and practitioners disagree. For example, renowned gender therapists Dr. Laura Edwards-Leeper and Dr. Erica Anderson (who, as mentioned above, identifies as a transgender woman) have recently spoken out arguing that children and adolescents are being subjected to transition, puberty blockers and hormonal intervention far too quickly, when careful and extended psychotherapy and investigation for potential causes of feelings of dysphoria (such as prior sexual abuse) should be the first port of call and might resolve the dysphoria. (Edwards-Leeper & Anderson 2021; Davis 2022.)

61. In a recently published position statement on gender dysphoria, the Royal Australian and New Zealand College of Psychiatrists emphasized the critical nature of mental health treatment for gender dysphoric minors, stressing "the importance of the psychiatrist's role to undertake thorough assessment and evidence-based treatment ideally as part of a multidisciplinary team, especially highlighting co-existing issues which may need addressing and treating." The Royal College also emphasized the importance of assessing the "psychological state and context in which Gender Dysphoria has arisen," before any treatment decisions are made. (RANZCP, 2021.).

62. In contrast the Australian organization linked to WPATH, AusPATH recently published its guidelines for the handling of gender dysphoria in youthful patients. A review of their literature review supporting their recommendations found a decided lack of accurate quotation of the findings of many of the articles that they cited in support of their policies. (Clayton 2022.)

63. Dr. Paul Hruz of the University of Washington St. Louis Medical School has noted, "The WPATH has rejected psychological counseling as a viable means to address sex–gender discordance with the claim that this approach has been proven to be unsuccessful and is harmful (Coleman et al. 2012). Yet the evidence cited to support this assertion, mostly from case reports published over forty years ago, includes data showing patients who benefited from this approach (Cohen-Kettenis and Kuiper 1984)." (Hruz 2020.)

64. WPATH issued its long overdue Version 8 of its Standards of Care in September 2022. It is 263 pages, 140 more pages than Version 7, making it the longest such document for any treatment guidelines. It recommends ICD-11 criteria, has no age limit for hormones and puberty blockers, and has been criticized as having the same problems as Version 7 (Dahlen et al. 2021; Dahlen 2022). The "World" in WPATH's name should not be understood that everywhere there is agreement with its proclaimed standards. As I explain below, the UK,

Finland, Sweden, and France have clearly come to different conclusions from those expressed by WPATH.

D. Internationally, there has been a recent marked trend against the use of puberty blockers and cross-sex hormones.

65. Further to extensive evidence reviews by national medical bodies (which I discuss later) four European countries have revised their practices around the use of puberty blockers and cross-sex hormones, as well as issuing strong cautions around their use.

66. The main gender clinic in Sweden has declared that it will no longer authorize use of puberty blockers for minors below the age of 16. Finland has similarly reversed its course, issuing new guidelines that allow puberty blockers only on a case-by-case basis after an extensive psychiatric assessment.

67. A landmark legal challenge against the UK's National Health Service in 2020 by "detransitioner" Keira Bell led to the suspension of the use of puberty blockers and new procedures to ensure better psychological care, as well as prompting a thorough evidence review by the National Institute for Health and Care Excellence (NICE 2021a; NICE 2021b).[6] Dr. Hillary Cass and her staff recently published an Independent Review of the UK's treatment model. They recommended that the Tavistock and Portman NHS Foundation Trust gender clinic

[6] The decision requiring court approval for administration of hormones to any person younger than age 16 was later reversed on procedural grounds by the Court of Appeal.

in London (Tavistock)—the world's largest dedicated gender clinic—should be replaced by regional centers with an "appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population." (Cass 2022b, Brooks 2022.) These regional referral centers will no longer function in the UK after March 2023.

68. France's Académie Nationale de Médecine issued a statement in February 2022 urging "great medical caution" when treating gender dysphoric youth "given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause."[7]

69. Given these developments, it is evident that U.S. Assistant Secretary of Health Levine's recent remark that there is "no argument among medical professionals . . . about the value and the importance of gender-affirming care"[8] does not accurately reflect the current state of scientific opinion on the topic. It is shocking to read this statement, by such a high-ranking government official, considering it is so clearly false.

[7] This statement is available at: https://segm.org/France-cautions-regarding-puberty-blockers-and-cross-sex-hormones-for-youth.

[8] The NPR article is available at: https://www.npr.org/sections/health-shots/2022/04/29/1095227346/rachel-levine-calls-state-anti-lgbtq-bills-disturbing-and-dangerous-to-trans-you

E. Opinions and practices vary widely with respect to the administration of puberty blockers and cross-sex hormones.

70. There is likewise no broadly accepted standard of care with respect to use of puberty blockers. The WPATH "Standards of Care" Version 7 explicitly recognize the lack of any consensus on this important point, stating: "Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. . . The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings." (WPATH 2012 at 13.)[9]

71. The use of puberty blockers as a therapeutic intervention for gender dysphoria is often justified by reference to the seminal work of a respected Dutch research team that developed a protocol that administered puberty blockers to children no younger than age 14. However, many clinics in North America now administer puberty blockers to children at much younger ages than the "Dutch Protocol" allows. (Zucker 2019.) The Dutch protocol only treated children with

[9] For the last decade, Version 7 of WPATH's "Standards of Care" document has been in effect and has influenced US treatment patterns in 177 clinics. WPATH's Version 8 already has stirred considerable controversy. I will be periodically referring to each version. It is too early to tell how WPATH's revised recommendations will affect American youth.

these characteristics: a stable cross gender identity from early childhood; dysphoria that worsened with the onset of puberty; were otherwise psychologically healthy; had healthy families; the patient and family agreed to individual and family counselling throughout the protocol. But the experience and results of the Dutch model are being used as a justification for giving puberty blockers to children who differ considerably from these criteria. Its authors have also recently noted this fact. (de Vries 2020.) In two publications, my co-authors and I provided detailed criticisms of the two seminal studies by deVries et al. (Levine et al. 2022; Abbruzzee et al. 2022.) As of this writing, *Reconsidering Informed Consent for Transgender-Identified Children, Adolescents, and Young Adults* has been widely promulgated and is among the top 5% of all scientific articles that have been downloaded since publishers have been keeping track. Subsequently, another author shed further light on the history and limitations of these two studies. (Biggs 2022c.) These recent criticisms may be contributing to the European hesitation about the use of puberty blockers.

72. Zucker notes that "it is well known" that clinicians are administering cross-sex hormones, and approving surgery, at ages lower than the minimum age thresholds set by that "Dutch Protocol." (Zucker 2019 at 5.)

73. Some voices in the field are now publicly arguing that *no* comprehensive mental health assessment at all should be required before putting

teens on puberty blockers or cross-sex hormones (Ghorayshi 2022), while Dr. Anderson and Dr. Edwards-Leeper argue that U.S. practitioners are already moving too quickly to hormonal interventions. (Edwards-Leeper & Anderson 2021; Davis 2022.)

74. In 2018, a committee of the American Academy of Pediatricians issued a statement supporting administration of puberty blockers to children diagnosed with gender dysphoria. It is also true that no other American medical association has endorsed the use of puberty blockers, and that pediatricians are neither endocrinologists nor psychiatrists. Dr. James Cantor published a peer-reviewed paper detailing that the Academy's statement is not evidence-based and misdescribed the few scientific sources it did reference. (Cantor 2019.) It has been well noted in the field that the AAP has declined invitations to publish any rebuttal to Dr. Cantor's analysis and is currently refusing requests from both inside and outside the organization to review the 2018 policy shift. But this is all part of ongoing debate, simply highlighting the absence of any generally agreed standard of care. It is evident that opinions and practices are all over the map. In 2022, the same committee of the AAP modified their recommendation supporting alternative treatments but still held out that affirmative care is still a viable option. Evidence after all is required for policy decisions and the 2018 evidence base is now widely appreciated as insubstantial.

75. While there is too little meaningful clinical data and no consensus concerning best practices or a "standard of care" this area, there are long-standing ethical principles that do or should bind all medical and mental health professionals as they work with, counsel, and prescribe for these individuals (Levine et al. 2022).

76. One of the oldest and most fundamental principles guiding medical and psychological care—part of the Hippocratic Oath—is that the physician must "do no harm." This states an ethical responsibility that cannot be delegated to the patient. Physicians themselves must weigh the risks of treatment against the harm of not treating. If the risks of treatment outweigh the benefits, principles of medical ethics prohibit the treatment.

IV. GENDER IDENTITY IS EMPIRICALLY NOT FIXED FOR MANY INDIVIDUALS.

A. Transgender identity has not been shown to be biologically based, and its epidemiology demonstrates large and radical changes across time and geography.

77. While advocates of affirmative care assert that gender identity is a biological phenomenon, there is no medical consensus that transgender identity has any biological basis—that is, it is not dictated by embryonic development. There is considerable well-documented evidence that is inconsistent with the hypothesis of a biological basis for gender identity—at least in the large majority of currently-presenting patients.

78. The Endocrine Society 2017 Guidelines recognize: "With current knowledge, we cannot predict the psychosexual outcome for any specific child" and "there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty." (Hembree et al. 2017 at 3876.) I offer the opinion that even after the first signs of puberty, physicians cannot be certain that the emerging trans-identified early adolescent will persist in his or her trans identity.

79. It is scientifically apparent that, no biological measurement has been identified that provides any ability to predict which children will exhibit, and which children will persist in, gender dysphoria or a transgender identification. In fact, there is substantial evidence that the "biological basis" theory is incorrect.

80. **Vast changes in incidence:** Historically, there were very low reported rates of gender dysphoria or transgender identification. In 2013, the DSM-5-TR estimated the incidence of gender dysphoria in adults to be at 2-14 per 100,000, or between 0.002% and 0.014%. (APA 2013 at 454.) Recently however, these numbers have increased dramatically, particularly in adolescent populations. Recent surveys estimate that between 2-9% of high school students self-identify as transgender or "gender non-conforming" with a significantly large increase in

adolescents claiming "nonbinary" gender identity as well. (Johns et al. 2019; Kidd et al. 2021.)

81. Consistent with these surveys, gender clinics around the world have seen numbers of referrals increase rapidly in the last decade, with the Tavistock clinic in London seeing a 30-fold increase in the last decade (GIDS 2019), and similar increases being observed in Finland (Kaltiala-Heino et al. 2018), the Netherlands (de Vries 2020), and Canada (Zucker 2019). The rapid change in the number of individuals experiencing gender dysphoria points to social and cultural, not biological, causes.

82. **Large change in sex ratio:** In recent years there has been a marked shift in the sex ratio of patients presenting with gender dysphoria or transgender identification. The Tavistock clinic in London saw a ratio of 4 biological females(F):5 biological males(M) shift to essentially 11F:4M in a decade. (GIDS 2019.) One researcher summarizing multiple sources documented a swing of 1F:2M or 1F:1.4M through 2005 to 2F:1M generally (but as high as 7F:1M) in more recent samples. (Zucker 2019 at 2.) This phenomenon has been noted by Dr. Erica Anderson, who said: "The data are very clear that adolescent girls are coming to gender clinics in greater proportion than adolescent boys. And this is a change in the last couple of years. And it's an open question: What do we make of that? We don't really know what's going on. And we should be concerned about

it." (Davis 2022.) Again, this large and rapid change in who is experiencing gender dysphoria points to social, not biological, causes. The fact of these shifts in incidence and sex ratios is not controversial; the interpretation of them seems to be contentious.

83. **Clustering**: Littman's study documented "clustering" of new presentations of gender dysphoria among natal females in specific schools and among specific friend groups. Her work documented what many clinicians and parents had been observing. This points strongly to social causes for gender dysphoria at least among the adolescent females. (Littman 2018.)

84. **Desistance:** There are very high levels of desistance among children diagnosed with gender dysphoria (Cantor 2019). There are increasing (or at least increasingly vocal) numbers of individuals who first asserted a transgender identity during or after adolescence, underwent substantial medical interventions to "affirm" that trans-identity, and then "desisted" and reverted to a gender identity congruent with their sex (Entwistle 2020; Littman 2021; Vandenbussche 2021; Hall et al. 2021.) (See Section IV.C below.) These narratives, too, point to a social and/or psychological cause, rather than a biological one.

85. **"Fluid" gender identification:** Advocates and others observe that recent forms of gender identities are not uniformly binary. Rather they now span an almost endless range of gender identity self-labels, which a given individual

may try on, inhabit, and often discard. (A recent article identifies 72.[10]) This, of course, presents a compelling argument that gender identity is not fixed prenatally. It illustrates that post-natal intrapsychic and social forces interact in unseen ways to shape and reshape gender identities.

86. I frequently read attempts to explain away the points raised above. They include: these gender identity problems always existed, but children are now learning that there are effective treatments for their dilemma and are simply seeking them. And; children have hidden their trans identity throughout childhood and now that trans people are recognized and accepted, they are presenting themselves. And; now pediatricians realize that girls can have gender dysphoria and are referring them to gender clinics. But these are mere hypotheses unsupported by evidence. One set of unproven hypotheses cannot provide support for the unproven hypothesis of biological basis. And none of these hypotheses could even potentially explain the half century of failures to scientifically find a predictive biological marker of transgender identification.

87. **Therapies affect gender identity outcomes:** Finally, the evidence shows that therapeutic choices can have a powerful effect on whether and how gender identity does change, or gender dysphoria desists. Social transition of

[10] Allarakha, *What Are the 72 Other Genders?*, MedicineNet, available at: https://www.medicinenet.com/what_are_the_72_other_genders/article.htm

juveniles, for instance, strongly influences gender identity outcomes to such an extent that it has been described a "unique predictor of persistence." (See Section V.B below.) This observation, too, cuts against the hypothesis of biological origin.

B. Most children who experience gender dysphoria ultimately "desist" and achieve comfort with their biological sex.

88. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times in different countries have reported that in the large majority of patients, absent social transition or puberty blocking hormone therapy, the child's trans identity does *not* persist through puberty.

89. A recent article reviewed all existing follow-up studies that the author could identify of children diagnosed with gender dysphoria (11 studies) and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor 2019 at 1.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance." (Adelson et al. 2012 at 963; see also Cohen-Kettinis 2008 at 1895.) The Endocrine Society recognized this important baseline fact in its 2017 Guidelines. (Hembree 2017 at 3879.) It should be noted that the reason that the Dutch Protocol waited until age 14 to initiate puberty

blockers was that it was well known by 2000 that many children would desist if left free of hormonal intervention until that age.

90. Findings of high levels of desistance among children who experience gender dysphoria or incongruence have been reaffirmed in the face of critiques through thorough reanalysis of the underlying data. (Zucker 2018.)

91. It is vital to realize that it is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. Affirmative clinicians, however, are making recommendations based on their individual assessment of the child's "severity," which is a dubious categorization.

92. It does appear that prevailing circumstances during particularly formative years can have a significant impact on the outcome of a juvenile's gender dysphoria. A 2016 study reviewing the follow-up literature noted that "the period between 10 and 13 years" was "crucial" in that "both persisters and desisters stated that the changes in their social environment, the anticipated and actual feminization or masculinization of their bodies, and the first experiences of falling in love and sexual attraction in this period, contributed to an increase (in the persisters) or decrease (in the desisters) of their gender related interests, behaviors, and feelings of gender discomfort." (Ristori & Steensma 2016 at 16.) As I discuss in Section VI below, there is considerable evidence that early transition and affirmation causes far more children to persist in a transgender identity.

C. Desistance is increasingly observed among teens and young adults who first manifest GD during or after adolescence.

93. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." Young "detransitioners" (individuals in the process of reidentifying with their birth sex after having undergone a gender transition) are now receiving increasing attention in clinical literature. (On March 12, 2022, the First Annual International Detransition Awareness Day was held.)

94. Recently, a professor of endocrinology at Harvard Medical School and Director of Transgender Medicine at Boston Beth Israel Deaconess Medical Center, cited two major studies to observe that claims of low rates of desistance or regret among those who have transitioned may be inaccurate due to strikingly high rates of subjects "lost to follow-up" in prospective studies. (Irwig 2022.)

95. Almost all scientific articles on this topic have appeared within the last few years. Perhaps this historic lack of coverage is not entirely surprising – one academic who undertook an extensive review of the available scientific literature in 2021 noted that the phenomenon was "socially controversial" in that it "poses significant professional and bioethical challenges for those clinicians working in the field of gender dysphoria." (Expósito-Campos 2021 at 270.) This review reported on multifarious reasons for why individuals were motivated to

detransition, which included coming to "understand how past trauma, internalized sexism, and other psychological difficulties influenced the experience of GD."

96. In 2021, Lisa Littman of Brown University conducted a ground-breaking study of 100 teenage and young adults who had transitioned and lived in a transgender identity for a number of years, and then "detransitioned" or changed back to a gender identity matching their sex. She noted that the "visibility of individuals who have detransitioned is new and may be rapidly growing." (Littman 2021 at 1.) Of the 100 detransitioners, 60% reported that their decision to detransition was motivated (at least in part) by the fact that they had become more comfortable identifying as their natal sex, and 38% had concluded that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition. (Littman 2021 at 9.)

97. A significant majority (76%) did not inform their clinicians of their detransition. (Littman 2021 at 11.)

98. A similar study that recruited a sample of 237 detransitioners (the large majority of whom had initially transitioned in their teens or early twenties) similarly reported that a common reason for detransitioning was the subject's conclusion that his or her gender dysphoria was related to other issues (70% of the sample). (Vandenbussche 2021.)

99. The existence of increasing numbers of youth or young adult detransitioners has also been recently noted by Dr. Edwards-Leeper and Dr. Anderson. (Edwards-Leeper & Anderson 2021.) Edwards-Leeper and Anderson noted "the rising number of detransitioners that clinicians report seeing (they are forming support groups online)" which are "typically youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it." Other clinicians working with detransitioners have also noted the recent phenomenon. (Marchiano 2020.)

100. A growing body of evidence suggests that for many teens and young adults, a post-pubertal onset of transgender identification can be a transient phase of identity exploration, rather than a permanent identity, as evidenced by a growing number of young detransitioners (Entwistle 2020; Littman 2021; Vandenbussche 2021). Previously, the rate of detransition and regret was reported to be very low, although these estimates suffered from significant limitations and were likely undercounting true regret (D'Angelo 2018). As gender-affirmative care has become popularized, the rate of detransition appears to be accelerating.

101. A recent study from a UK adult gender clinic observed that 6.9% of those treated with gender-affirmative interventions detransitioned within 16 months, and another 3.4% had a pattern of care suggestive of detransition, yielding a rate of probable detransition in excess of 10%. Another 21.7%, however,

disengaged from the clinic without completing their treatment plan. While some of these individuals later re-engaged with the gender service, the authors concluded, "detransitioning might be more frequent than previously reported." (Hall et al. 2021).

102. Another study from a UK primary care practice found that 12.2% of those who had started hormonal treatments either detransitioned or documented regret, while the total of 20% stopped the treatments for a wider range of reasons. The mean age of their presentation with gender dysphoria was 20, and the patients had been taking gender-affirming hormones for an average 5 years (17 months-10 years) prior to discontinuing. Comparing these much higher rates of treatment discontinuation and detransition to the significantly lower rates reported by the older studies, the researchers noted: "Thus, the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields" (Boyd et al. 2022 at 15.) Indeed, given that regret may take up to 8-11 years to materialize (Dhejne et al. 2014; Wiepjes et al. 2018), many more detransitioners are likely to emerge in the coming years. Detransitioner research is still in its infancy, but the Littman and Vandenbussche studies in 2021 both report that detransitioners from the recently transitioning cohorts feel they were rushed into

medical gender-affirmative interventions with irreversible effects, often without the benefit of appropriate, or in some instances any, psychologic exploration.

V. TRANSITION AND AFFIRMATION IS AN IMPORTANT PSYCHOLOGICAL AND MEDICAL INTERVENTION THAT CHANGES GENDER IDENTITY OUTCOMES.

A. If both a typical gender or a transgender long-term gender identity outcome are possible for a particular patient, the alternatives are not medically neutral.

103. Where a juvenile experiences gender dysphoria, the gender identity that is stabilized will have a significant impact on the course of their life. Living in a transgender identity for a time will make desistance, if it is ever considered, more difficult to accomplish.

104. If the juvenile desists from the gender dysphoria and becomes reasonably comfortable with a gender identity congruent with their sex—the most likely outcome from a statistical perspective absent affirming intervention—the child will not require ongoing pharmaceutical maintenance, will not have their fertility destroyed, and will not have early in life onset of sexual dysfunction.

105. However, if the juvenile persists in a transgender identity, under current practices, the child is most likely to require regular administration of hormones for the rest of their lives, exposing them to significant physical, mental health, and relational risks (which I detail in Section VIII below), as well as being hormonally rendered infertile and subsequently surgically rendered sterile.

B. Social transition of young children is a powerful psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance.

106. Social transition has a critical effect on the persistence of gender dysphoria. It is evident from the scientific literature that recommending and encouraging social transition before puberty is a powerful intervention that dramatically changes gender identity developmental outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood." (Guss et al. 2015 at 421.) Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their natal sex—instead persist in a transgender identity. (Zucker 2018 at 7.)

107. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I reviewed above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete

social transition before puberty had desisted when surveyed at age 15 or older. (Zucker 2018 at 7[11]; Steensma et al. 2013.)[12] Another researcher observed that a partial or complete gender social transition prior to puberty "proved to be a unique predictor of persistence." (Singh et al. 2021 at 14.)

108. Some vocal practitioners of prompt affirmation and social transition even proudly claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex.[13] This is a very large change as compared to the desistance rates documented apart from social transition.

109. Even voices generally supportive of prompt affirmation and social transition are acknowledging a causal connection between social transition and this change in outcomes. As the Endocrine Society recognized in its 2017 Guidelines: "If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty. . . [S]ocial transition

[11] Zucker found social transition by the child to be strongly correlated with persistence for natal boys, but not for girls. (Zucker 2018 at 5.)

[12] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma 2013 at 584.

[13] *See, e.g.,* Ehrensaft 2015 at 34: "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."

(of children with GD/gender incongruence) has been found to contribute to the likelihood of persistence." (Hembree et al. 2017 at 3879.) These interventions were not based on follow-up psychosocial, educational, or medical evaluations during adolescence or young adulthood. Some physicians simply thought this would be best without considering the experimental nature of their recommendations (Rafferty et al, 2018). I agree with Dr. Ken Zucker who has written that social transition in children must be considered "a form of psychosocial treatment." (Zucker 2020 at 1.) Indeed, I would characterize social transitioning as significant treatment in the life of the child.

110. Moreover, as I review below, social transition cannot be considered or decided upon as a stand-alone decision based only on the present clinical situation. Studies show that engaging in social transition starts a juvenile on a "conveyor belt" path that leads in the vast majority of cases to the administration of puberty blockers, which in turn leads in the vast majority of cases to the administration of cross-sex hormones. The emergence of this well-documented path means that the implications of taking puberty blockers *and* cross-sex hormones must be taken into account even where "only" social transition is being considered or requested by the child or family. As a result, there are a number of important "known risks" associated with social transition.

C. Administration of puberty blockers is a powerful medical and psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance on the historically observed timeline.

111. Advocates of affirmative care speak of the use of puberty blockers as though this major hormonal disruption of some of the most basic aspects of ordinary human development were entirely benign, acting as a "pause." This optimistic view is not based on science. In fact, it should be understood that puberty blockers are usually administered to early-stage adolescents as part of a path that includes social transition. Moreover, medicine does not know what the long-term health effects on bone, brain, and other organs are of a "pause" between ages 11-16. Medicine also does not know if the long-term effects of these compounds are different in boys than in girls. The mental health professional establishment likewise does not know the long-term effects on coping skills, interpersonal comfort, and intimate relationships of this "pause" while one's peers are undergoing their maturational gains in these vital arenas of future mental health. I address medical, social, and mental health risks associated with the use of puberty blockers in Section VIII. Here, I note that the data strongly suggests that the administration of puberty blockers, too, must be considered to be a component of a "psychosocial treatment" with complex implications, rather than a "pause."

112. Multiple studies show that the large majority of children who begin puberty blockers go on to receive cross-sex hormones. (de Vries 2020 at 2.) A

recent study by the Tavistock clinic found that 98% of adolescents who underwent puberty suppression continued on to cross-sex hormones. (Carmichael et al. 2021 at 12.)[14] Beyond hormonal intervention, three Dutch clinical follow-up studies have shown that *all* of the adolescents who received puberty blockers and/or cross-sex hormones went on to receive surgery. (Leibowitz & de Vries 2016, 23.)

113. These studies demonstrate that going on puberty blockers virtually eliminates the possibility of desistance in juveniles. Rather than a "pause," puberty blockers appear to act as a psychosocial "switch," decisively shifting many children to a persistent transgender identity. Therefore, as a practical and ethical matter the decision to put a child on puberty blockers must be considered as the equivalent of a decision to put that child on cross-sex hormones, with all the considerations and informed consent obligations implicit in that decision.

VI. TRANSITION AND AFFIRMATION ARE EXPERIMENTAL THERAPIES THAT HAVE NOT BEEN SHOWN TO IMPROVE MENTAL OR PHYSICAL HEALTH OUTCOMES BY YOUNG ADULTHOOD.

114. It is undisputed that children and adolescents who present with gender dysphoria exhibit a very high level of mental health comorbidities. (Section II.C.) Whether the gender dysphoria is cause or effect of other diagnosed or undiagnosed

[14] *See also* Brik 2020 where Dutch researchers found nearly 97% of adolescents who received puberty blockers proceeded to cross-sex hormones.

mental health conditions, or whether these are merely coincident comorbidities, is hotly disputed, but the basic fact is not.

A. The knowledge base concerning therapies for gender dysphoria is "very low quality."

115. At the outset, it is important for all sides to admit that the knowledge base concerning the causes and treatment of gender dysphoria has low scientific quality.

116. In evaluating claims of scientific or medical knowledge, it is axiomatic in science that no knowledge is absolute, and to recognize the widely accepted hierarchy of reliability when it comes to "knowledge" about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such "knowledge" may be based upon data comprising:

a. Expert opinion—it is perhaps surprising to educated laypersons that expert opinion standing alone is the lowest form of knowledge, the least likely to be proven correct in the future, and therefore does not garner as much respect from professionals as what follows.

b. A single case or series of cases (what could be called anecdotal evidence) (Levine 2016 at 239.)

c. A series of cases with a control group

d. A cohort study

e. A randomized double-blind clinical trial

f. A review of multiple trials

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

117. Prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that "Different clinical approaches have been advocated for childhood gender discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against … possible deleterious effects." (Adelson et al. at 968–69.) Similarly, the American Psychological Association has stated, "because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children." (APA 2015 at 842.)

118. Critically, "there are no randomized control trials with regard to treatment of children with gender dysphoria." (Zucker 2018 at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect

of alternative treatments, the knowledge base remains primarily at the level of the practitioner's exposure to individual cases, or multiple individual cases. As a result, claims to certainty in this area are often not justifiable. (Levine 2016 at 239.)

119. Within the last two years, at least four formal independent evidence reviews concerning hormonal interventions for gender dysphoria have been conducted. They each found all the available clinical evidence to be very low quality.

120. The British National Health Service (NHS) commissioned formal "evidence reviews" of all clinical papers concerning the efficacy and safety of puberty blockers and cross-sex hormones as treatments for gender dysphoria. These evidence reviews were performed by the U.K. National Institute for Health and Care Excellence (NICE), applying the respected "GRADE" criteria for evaluating the strength of clinical evidence.

121. Both the review of evidence concerning puberty blockers and the review of evidence concerning cross-sex hormones were published in 2020, and both found that *all* available evidence as to both efficacy and safety was "very low quality" according to the GRADE criteria. (NICE 2021a; NICE 2021b.) "Very low quality" according to GRADE means there is a high likelihood that the patient *will not experience* the hypothesized benefits of the treatment. (Balshem et al. 2011.)

Specifically in relation to puberty blockers, the NICE review found that every study conducted thus far had been a "small, uncontrolled observational stud[y]," "subject to bias and confounding," with "results … of very low certainty." (NICE 2021a at 13.)

122. Similarly, the highly respected Cochrane Library—the leading source of independent systematic evidence reviews in health care—commissioned an evidence review concerning the efficacy and safety of hormonal treatments now commonly administered to "transitioning transgender women" (i.e., testosterone suppression and estrogen administration to biological males). That review, also published in 2020, concluded that "We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition." (Haupt et al. 2020 at 2.) It must be understood that both the NICE and the Cochrane reviews considered *all* published scientific studies concerning these treatments.

123. More recently in the United States, Florida's Agency for Health Care Administration released an extensive literature review conducted by researchers at McMaster University in June 2022, and concluded: "Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to [generally

accepted professional medical standards] and are experimental and investigational." (Division of Florida Medicaid 2022 at 3.)

124. Sweden and Finland's reviews reached similar conclusions.

125. As to social transition, as I have noted above, considerable evidence suggests that socially transitioning a pre-pubertal child puts him or her on a path from which very few children escape—a path which includes puberty blockers and cross-sex hormones before age 18. For hormonally masculinized biological girls, this often leads to bilateral mastectomies before the age of 18. When guiding parents about a decision about social transition of their child, the discussion should include what is known and what is unknown about the effects of those expected later hormonal and surgical interventions not what that means for their adulthood.

126. I discuss safety considerations in Section VIII below. Here, I detail what is known about the effectiveness of social and hormonal transition and affirmation to improve the mental health of individuals diagnosed with gender dysphoria.

B. Youth who adopt a transgender identity show no durable improvement in mental health after social, hormonal, or surgical transition and affirmation.

127. As I noted above, the evidence reviews for the efficacy and safety of hormonal interventions published in 2020 concluded that the supporting evidence is so poor that there is "a high likelihood that the patient will not experience the

hypothesized benefits of the treatment." There is now some concrete evidence that on average they do not experience those benefits.

128. An important paper published in 2021 by Tavistock clinic clinicians provided the results of the first longitudinal study that measured widely used metrics of general psychological function and suicidality before commencement of puberty blockers, and then at least annually after commencing puberty blockers. After up to three years, they "found no evidence of change in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalizing or externalizing problems or self-harm" as compared to the pre-puberty-blocker baseline evaluations. "Outcomes that were not formally tested also showed little change." (Carmichael at al. 2021 at 18-19.) Similarly, a study by Bränström and Pachankis of the case histories of a set of individuals diagnosed with GD in Sweden found no positive effect on mental health from hormonal treatment. (Landen 2020.)

129. A cohort study by authors from Harvard and Boston Children's Hospital found that youth and young adults (ages 12-29) who self-identified as transgender had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater proportion of

transgender youth accessed inpatient mental health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services. (Reisner et al. 2015 at 6.) Similarly, a recent longitudinal study of transgender and gender diverse youth and young adults in Chicago found rates of alcohol and substance abuse "substantially higher than those reported by large population-based studies of youth and adults." (Newcomb et al. 2020 at 14.) Members of the clinical and research team at the prominent Dutch VU University gender dysphoria center recently compared mental health metrics of two groups of subjects before (mean age 14.5) and after (mean age 16.8) puberty blockers. But they acknowledged that the structure of their study meant that it "can . . . not provide evidence about . . . long-term mental health outcomes," and that based on what continues to be extremely limited scientific data, "Conclusions about the long-term benefits of puberty suppression should . . . be made with extreme caution." In other words, we just don't know. (van der Miesen et al. 2020 at 703.)

C. Long-term mental health outcomes for individuals who persist in a transgender identity are poor.

130. The responsible MHP cannot focus narrowly on the short-term happiness of the young patient but must instead consider the happiness and health of the patient from a "life course" perspective. When we look at the available studies of individuals who continue to inhabit a transgender identity across adult years, the results are strongly negative.

131. In the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than in the general population. These crude death rates include significantly elevated rates of substance abuse as well as suicide. (Levine 2017 at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period. (Dhejne et al. 2011; Simonsen et al. 2016.) The Swedish follow-up study similarly found a suicide rate in the post-SRS population 19.1 times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine 2017 at 10.)

132. A recent study in the American Journal of Psychiatry reported high mental health utilization patterns of adults for ten years after surgery for approximately 35% of patients. (Bränström & Panchankis, 2020.) Indeed, earlier Swedish researchers in a long-term study of all patients provided with SRS over a 30-year period (median time since SRS of > 10 years) concluded that individuals who have SRS exhibit such poor mental health that they should be provided very long-term psychiatric care as the "final" transition step of SRS. (Dhejne et al. 2011 at 6-7.) Unfortunately, across the succeeding decade, in Sweden and elsewhere their suggestion has been ignored.

133. I will note that these studies do not tell us whether the subjects first experienced gender dysphoria as children, adolescents, or adults, so we cannot be certain how their findings apply to each of these subpopulations which represent quite different pathways. But in the absence of knowledge, we should be cautious.

134. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25 or older than does "watchful waiting" or ordinary psychotherapy.

135. The many studies that I have cited here warn us that as we look ahead to the patient's life as a young adult and adult, the prognosis for the physical health, mental health, and social well-being of the child or adolescent who transitions to live in a transgender identity is not good.

VII. TRANSITION AND AFFIRMATION DO NOT DECREASE, AND MAY INCREASE, THE RISK OF SUICIDE.

A. The risk of suicide among transgender youth is confused and exaggerated in the public mind.

136. While suicide is closely linked to mental health, I comment on it separately because rhetoric relating to suicide figures prominently in debates about responses to gender dysphoria.

137. Any discussion of suicide when considering younger children involves very long-range and, therefore, very uncertain prediction. Suicide in pre-

pubescent children is extremely rare, and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. Any suggestion otherwise is misinformed. Our focus for this topic, then, is on adolescents and adults, mindful that in a few short years, prepubertal children will be adolescents.

138. Some authors have reported rates of suicidal thoughts and behaviors among trans-identifying teens or adults ranging from 25% to as high as 52%, generally through non-longitudinal self-reports obtained from non-representative survey samples. (Toomey et al. 2018.) The vast majority, if not all studies, repeatedly demonstrate that transgender adolescents and homosexually identified agemates have elevated rates of suicidal thoughts when compared to their cis-gendered and heterosexual peers (Canetto et al. 2021). Advocates frequently assert that affirmative care is the only way to avoid the possibility of suicide. No statistically meaningful studies show that affirmation of children, adolescents, or adults reduces suicide, prevents future suicidal ideation, or improves long-term outcomes. For this to be demonstrated, prospective studies comparing two groups of gender dysphoric teens, one medicalized and one not, would need to be carried out over many years. The group who did not receive affirmative care might undergo either “watchful waiting” or psychotherapy. Such studies have not been initiated.

139. Moreover, a clear grasp of the differences between suicidal thoughts, suicidal gestures (that represent a cry for help, manipulation, or expression of rage), and sincere attempts to end life is required. Too often, in both public and professional discussions, suicidal thoughts are blurred with suicide. Yet the available data tells us that suicide among children and youth suffering from gender dysphoria is extremely rare.

140. An important analysis of data covering patients as well as those on the waiting list (and thus untreated) at Tavistock found a total of four completed suicides across 11 years' worth of patient data, reflecting an estimated cumulative 30,000 patient-years spent by patients under the clinic's care or on its waiting list. This corresponded to an annual suicide rate of 0.013%. The proportion of individual patients who died by suicide was 0.03%, which is orders of magnitude smaller than trans adolescents who self-report suicidal behavior or thoughts on surveys. (Biggs 2022b.)

141. Thus, only a minute fraction of trans-identifying adolescents who report thoughts or conduct considered to represent "suicidality" commit suicide. I agree with the statement by Dr. Zucker that the assertion by, for example, Karasic and Ehrensaft (2015) that completed suicides among transgender youth are "alarmingly high" "has no formal and systematic empirical basis." (Zucker 2019 at 3.)

142. In his study of the incidence of suicide, Biggs rightly cautions that it is "irresponsible to exaggerate the prevalence of suicide" (Biggs 2022b at 4). It is my opinion that telling parents—or even allowing them to believe from their Internet reading—that they face a choice between "a live son or a dead daughter" is both factually wrong and conspicuously unethical. Informed consent requires clinicians to tell the truth and ensure that their patients understand the truth. To be kind, the clinicians who believe such figures represent high risk of ultimate suicide during adolescence are ill-informed.

B. Transition of any sort has not been shown to reduce levels of suicide.

143. Every suicide is a tragedy, and steps that reduce suicide should be adopted. I have noted above that suicidality (that is, suicidal thoughts or behaviors, rather than suicide) is common among transgender adolescents and young adults before, during, and after social and medical transition. If a medical or mental health professional believes that an individual he or she is diagnosing or treating for gender dysphoria presents a suicide risk, in my view it is unethical for that professional merely to proceed with treatment for gender dysphoria and hope that "solves the problem." Rather, that professional has an obligation to provide or refer the patient for evidence-based therapies for addressing depression and suicidal thoughts that are well-known to the profession. (Levine 2016 at 242.)

144. There is in fact no evidence that social and/or medical transition reduces the incidence of suicide. Dutch researchers documented that suicides occur at a similar rate through all stages of transition, from pre-treatment assessment to post-transition follow-up (Wiepjes et al. 2020). On the contrary, the analysis of those who were patients of or on the waiting list of the Tavistock clinic, found that the suicide rate was not higher among those on the clinic's waiting list (and thus as-yet untreated), than for those who were patients under care. (Biggs 2022b.) Bränström and Pachankis, after correcting their original article, similarly acknowledge that their review of records of GD patients "demonstrated no advantage of surgery in relation to . . . hospitalizations following suicide attempts." (They did not include completed suicides in their study.)[15]

C. Long-term life in a transgender identity correlates with very high rates of completed suicide among adults.

145. As with mental health generally, the patient, parent, or clinician fearing the risk of suicide must consider not just the next month or year, but a life course perspective.

146. There are now five long-term studies that analyze completed suicides among those living in transgender identities into adulthood. The results vary significantly but are uniformly highly negative.

[15] Turban et al. (2020) has been described in press reports as demonstrating that administration of puberty suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

147. Dhejne reported a long-term follow-up study of Swedish subjects after sex reassignment surgery. Across the multi-year study, subjects who had undergone SRS committed suicide at 19.1 times the expected rate compared to general population controls matched by age and both sexes. MtF subjects committed suicide at 13.9 times the expected rate, and FtM subjects committed suicide at 40.0 times the expected rate. (Dhejne et al. 2011 Supplemental Table S1.)

148. Asscheman reported results of a long-term follow-up of all transsexual subjects of the Netherlands' leading gender medicine clinic who started cross-sex hormones before July 1, 1997, a total of 1331 patients. The Dutch system of medical and death records enables extensive follow-up. Median follow-up period was 18.5 years. The mortality rate among MtF patients was 51% higher than among the age-matched general population; the rate of completed suicide among MtF patients was six times that of the age-matched general population. (Asscheman et al. 2011.)

149. Asscheman et al. found that "No suicides occurred within the first 2 years of hormone treatment, while there were six suicides after 2-5 years, seven after 5-10 years, and four after more than 10 years of CSH treatment at a mean age of 41.5 years." (Asscheman et al. 2011 at 637-638.) Their data suggest that such short-term follow-up is engaging only with an initial period of hopeful optimism.

Short-term follow-ups will miss the feelings of disillusion and the increase in attempted and completed suicide in later years.

150. A retrospective, long-term study published in 2020 of a very large cohort (8263) of patients referred to the Amsterdam University gender clinic between 1972 and 2017 found that the annual rate of completed suicides among the transgender subjects was "three to four times higher than the general Dutch population." "[T]he incidence of observed suicide deaths was almost equally distributed over the different stages of treatment." The authors concluded that "vulnerability for suicide occurs similarly in the different stages of transition." (Wiepjes et al. 2020.) In other words, neither social nor medical transition reduced the rate of suicide.

151. As with Asscheman et al., Wiepjes et al. found that the median time between start of hormones and suicide (when suicide occurred) was 6.1 years for natal males, and 6.9 years for natal females. Again, short- or even medium-term studies will miss this suicide phenomenon.

152. A 2021 study analyzed the case histories of a cohort of 175 gender dysphoria patients treated at one of the seven UK adult gender clinics who were "discharged" (discontinued as patients) within a selected one-year period. The authors reported the rather shocking result that 7.7% (3/39) of natal males who were diagnosed and admitted for treatment, and who were between 17 and 24 years

old, were "discharged" because they committed suicide *during* treatment. (Hall et al. 2021, Table 2.)

153. None of these studies demonstrates that the hormonal or surgical intervention *caused* suicide. That is possible, but as we have seen, the population that identifies as transgender suffers from a high incidence of comorbidities that correlate with suicide. What these studies demonstrate—at the least—is that this remains a troubled population in need of extensive and careful psychological care that they generally do not receive, and that neither hormonal nor surgical transition and "affirmation" resolve their underlying problems and put them on the path to a stable and healthy life.

154. One prudent interpretation of these findings is that when evaluating the benefits and risks of affirmative care, a long-term perspective is required. Patients and their parents need to be informed about this information prior to affirmative care. It is not likely that educators are aware of long-term premature mortality data and the role that suicide plays among these adults.

155. In sum, claims that affirmation will reduce the risk of suicide for children and adolescents are not based on science. Instead, transition of any sort must be justified, if at all, as a life-enhancing measure, not a lifesaving measure. (Levine 2016 at 242.) In my opinion, this is an important fact that patients, parents, many MHPs, and educators fail to understand.

VIII. HORMONAL INTERVENTIONS ARE EXPERIMENTAL PROCEDURES THAT HAVE NOT BEEN PROVEN SAFE.

156. Advocates of affirmative care assert as a fact that social transition, puberty blockers, and cross-sex hormones are known to be "safe." This is not true. And a number of voices in the field also assert that puberty blockers act merely as a "pause" in the process of puberty-driven maturation, suggesting that this hormonal intervention has been proven to be fully reversible. This is also an unproven belief.

157. On the contrary, no studies have been done that meaningfully demonstrate that either puberty blockers or cross-sex hormones, as prescribed for gender dysphoria, are safe in other than the short run. No studies have attempted to determine whether the effects of puberty blockers, as currently being prescribed for gender dysphoria, are fully reversible. A recent study from Professor Biggs that carefully scrutinizes the history and evidence that supports treating children with puberty blockers and cross-sex hormones notes that "[hormonal] intervention was justified by claims that it was reversible and that it was a tool for diagnosis, but these claims are increasingly implausible." (Biggs 2022c at 1.) In fact, there are substantial reasons for concern that these hormonal interventions are not safe. Multiple researchers have expressed concern that the full range of possible harms have not even been correctly conceptualized. In July 2022, the FDA issued a warning that puberty blockers carry a risk of pseudotumor cerebri presenting with

swelling of the optic nerve, headaches, vomiting, elevated blood pressure, and eye muscle paralysis. (FDA, 2022.)

158. Because evidence demonstrates that pre-pubertal social transition is highly likely to lead to progression on to puberty blockers which in turn is highly likely to lead to the use of cross-sex hormones, physicians bear the ethical responsibility for a thorough informed consent process for parents and patients that includes this fact and its full implications. Informed consent does not mean sharing with the parents and patients what the doctor believes: it means sharing what is known and what is not known about the intervention. Much of what doctors believe is based on mere trust in what they have been taught. Neither they themselves nor their teachers may be aware of the scientific foundation and scientific limitations of what they are recommending.

A. Use of puberty blockers has not been shown to be safe or reversible for gender dysphoria.

159. As I noted above, the recent very thorough literature review performed for the British NHS concluded that *all* available clinical evidence relating to "safety outcomes" from administration of puberty blockers for gender dysphoria is of "very low certainty." (NHS 2020a at 6.)

160. In its 2017 Guidelines, the Endocrine Society cautioned that "in the future we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols" including "careful assessment of . . . the effects

of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development).” (Hembree et al. 2017 at 3874.) No such “careful” or “rigorous” evaluation of these very serious safety questions has yet been done.

161. Some advocates appear to assume that puberty blockers are “safe” because they have been approved by the Food and Drug Administration (FDA) for use to treat precocious puberty—a rare condition in which the puberty process may start at eight or younger. No such conclusion can be drawn. As the “label” for Lupron (one of the most widely prescribed puberty blockers) explains, the FDA approved the drug only *until* the “age was appropriate for entry into puberty.” The study provides no information at all as to the safety or reversibility of instead *blocking* healthy, normally timed puberty’s beginning, and *throughout* the years that body-wide continuing changes normally occur. Given the physical, social, and psychological dangers to the child with precocious puberty, drugs like Lupron are effective in returning the child to a puerile state without a high incidence of significant side effects—that is, they are “safe” to reverse the condition. But use of drugs to suppress normal puberty has multiple organ system effects whose long-term consequences have not been investigated.

162. **Fertility**: The Endocrine Society Guidelines rightly say that research is needed into the effect of puberty blockade on “gonadal function” and “sexual

development." The core purpose and function of puberty blockers is to prevent the maturation of the ovaries or testes, the sources of female hormones and male hormones when stimulated by the pituitary gland. From this predictable process fertility is accomplished within a few years. Despite widespread assertions that puberty blockers are "fully reversible," there has been no study published on the critical question of whether patients ever develop normal levels of fertility if puberty blockers are terminated after a "prolonged delay of puberty." The 2017 Endocrine Society Guidelines are correct that there are no data on achievement of fertility "following prolonged gonadotropin suppression" (that is, puberty blockade). (Hembree et al. 2017 at 3880.) Advocates stress that preservation of eggs and sperm can be achieved prior to cross sex hormone treatment so that fertility will not be damaged. What is not said is the puberty blockers interfere with viable development of sperm and ova when given early in puberty, the costs of "fertility preservation" is very high, and very few transgendered adolescents choose this option.

163. **Brain development:** The scientific literature is clear that important neurological growth and development in the brain occurs across puberty.[16] The anatomic and functional effect on brain development of blocking the natural puberty process has not been well studied. A prominent Australian clinical team

[16] *See* Blakemore et al. 2010.

recently expressed concern that "no data were (or are) available on whether delaying the exposure of the brain to a sex steroid affects psychosexual, cognitive, emotional, or other neuropsychological maturation." (Kozlowska et al. 2021 at 89.) In my opinion, given the observed correlation between puberty and brain development, the default hypothesis must be that there *would* be a negative impact. For the purpose of protecting patients all over the world, the burden of proof should be on advocates to first demonstrate to a reasonable degree of certainty that brain structure and its measurable cognitive and affect processing are not negatively affected. This recalls the ethical principle: Above All Do No Harm.

164. The Endocrine Society Guidelines state that side effects of pubertal suppression "may include . . . unknown effects on brain development," that "we need more rigorous evaluations of . . . the effects of prolonged delay of puberty in adolescents on . . . the brain (including effects on cognitive, emotional, social, and sexual development)," and stating that "animal data suggests there may be an effect of GnRH analogs [puberty blockers] on cognitive function." (Hembree et al. 2017 at 3874, 3882, 3883.)

165. Writing in 2022, Dr. Cass strongly flagged the risk of harm to brain development in her Interim Report, stating:

> "A closely linked concern [arising from use of puberty blockers] is the unknown impacts on development, maturation and cognition if a child or young person is not exposed to the physical, psychological, physiological,

> neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function and connectivity. During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans. If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when estrogen or testosterone is introduced later.
>
> "An international interdisciplinary panel has highlighted the importance of understanding the neurodevelopmental outcomes of pubertal suppression and defined an appropriate approach for investigating this further. However, this work has not yet been undertaken." (Cass 2022a.)

166. Given that respected voices have repeatedly raised concern about harm to the development of the adolescent's brain, one can only wonder how advocates continue to assert that use of puberty blockers is known to be "safe," and why this relevant question has not been scientifically investigated in a large group of natal males and females.

167. There has been a longitudinal study of one natal male child, assessed before, and again 20 months after, puberty suppression was commenced. It reported a reduction in the patient's "global IQ," measured an anomalous absence

of certain structural brain development expected during normal male puberty and hypothesized that "a plausible explanation for the G[lobal] IQ decrease should consider a disruption of the synchronic [i.e., appropriately timed] development of brain areas by pubertal suppression." (Schneider et al. 2017 at 7.) This should cause parents and practitioners serious concern.

168. Whether any impairment of brain development is "reversed" upon later termination of puberty blockade has, to my knowledge, not been studied. As a result, assertions by medical or mental health professionals that puberty blockade is "fully reversible" are unjustified and based on hope rather than science.

169. **Bone strength**: Multiple studies have documented adverse effects from puberty blockers on bone density. (Klink et al. 2015; Vlot et al. 2016; Joseph et al. 2019.) The most recent found that after two years on puberty blockers, the bone density measurements for a significant minority of the children had declined to clinically concerning levels. Density in the spines of some subjects fell to a level found in only 0.13% of the population. (Biggs 2021.) Some other studies have found less-concerning effects on bone density. While the available evidence remains limited and conflicting, it is not possible to conclude that the treatment is "safe."

170. **Psycho-social harm**: Puberty is a time of stress, anxiety, bodily discomfort during physical development, and identity formation for *all* humans.

No careful study has been done of the long-term impact on the young person's coping skills, interpersonal comfort, and intimate relationships from remaining puerile for, e.g., two to five years while one's peers are undergoing pubertal transformations, and of then undergoing an artificial puberty at an older age. However, pediatricians and mental health professionals hear of distress, concern, and social awkwardness in those who naturally have a delayed onset of puberty. In my opinion, individuals in whom puberty is delayed multiple years are likely to suffer at least subtle negative psychosocial and self-confidence effects as they stand on the sidelines witnessing their peers developing the social relationships (and attendant painful social learning experiences) that come with adolescence. (Levine 2018 at 9.) Social anxiety and social avoidance are common findings in the evaluation of trans-identified children and teens. Are we expected to believe that creating years of being further different than their peers has no lasting internal consequences? Do we ignore Adolescent Psychiatry's knowledge of the importance of peer groups among adolescents?

171. We simply do not know what all the psychological impacts of *not* grappling with puberty at the ordinary time may be, because it has not been studied. And we have no information as to whether that impact is "fully reversible."

172. In addition, since the overwhelming proportion of children who begin puberty blockers continue on to cross-sex hormones, it appears that there is an important element of "psychological irreversibility" in play. The question of to what extent the physical and developmental impacts of puberty blockers might be reversible is an academic one, if psycho-social realities mean that very few patients well ever be able to make that choice once they have started down the road of social transition and puberty blockers.

B. Use of cross-sex hormones in adolescents for gender dysphoria has not been shown to be medically safe except in the short term.

173. As with puberty blockers, all evidence concerning the safety of extended use of cross-sex hormones is of "very low quality." The U.K. NICE evidence review cautioned that "the safety profiles" of cross-sex hormone treatments are "largely unknown," and that several of the limited studies that do exist reported high numbers of subjects "lost to follow-up," without explanation—a worrying indicator. (NICE 2020b.)

174. The 2020 Cochrane Review reported that: "We found insufficient evidence to determine the . . . safety of hormonal treatment approaches for transgender women in transition." (Haupt et al. 2020 at 4.) Even the Endocrine Society tagged all its recommendations for the administration of cross-sex hormones as based on "low quality evidence." (Hembree et al. 2017 at 3889.)

175. **Sterilization**: It is undisputed, however, that harm to the gonads is an expected effect, to the extent that it must be assumed that cross-sex hormones will render the patient to be infertile. Thus, the Endocrine Society 2017 Guidelines caution that "[p]rolonged exposure of the testes to estrogen has been associated with testicular damage," that "[r]estoration of spermatogenesis after prolonged estrogen treatment has not been studied," and that "[i]n biological females, the effect of prolonged treatment with exogenous testosterone upon ovarian function is uncertain." (Hembree et al. 2017 at 3880.)[17] The Guidelines go on to recommend that the practitioner counsel the patient about the (problematic and uncertain) options available to collect and preserve fertile sperm or ova before beginning cross-sex hormones. Only a very small percentage of adolescents and their families elect gamete storage. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been systematically studied within the transgender population, regret has been clearly described.[18] The opportunity to be a parent may be a human, emotional need, and

[17] *See also* Guss et al. 2015 at 4 ("a side effect [of cross-sex hormones] may be infertility") and at 5 ("cross-sex hormones . . . may have irreversible effects"); Tishelman et al. 2015 at 8 (Cross-sex hormones are "irreversible interventions" with "significant ramifications for fertility").

[18] *See* Cohn, Corrina, *Opinion: What I Wish I'd Known When I was 19 and had Sex Reassignment Surgery*, Washington Post (April 11, 2022) https://www.washingtonpost.com/opinions/2022/04/11/i-was-too-young-to-decide-about-transgender-surgery-at-nineteen/

so should be considered an important risk factor when considering gender transition for any patient. Future capacity to reproduce is not generally of any concern to transgender individuals at puberty. This and the consequences discussed in paragraphs 176-180 constitute an argument that the young patient is simply too immature to make such fateful decisions.

176. **Sexual response**: Puberty blockers prevent maturation of the sexual organs and response. Some, and perhaps many, transgender individuals who did not go through puberty consistent with their sex and are then put on cross-sex hormones face significantly diminished sexual response as they enter adulthood and are unable ever to experience orgasm. Prominent transgender surgeon Marci Bowers, who has performed over 2000 vaginoplasties (that is, creation of an artificial vagina for a biological male) has stated that "every single [male] child . . . who was truly blocked at Tanner stage 2" and later proceeded to surgical transition "has never experienced orgasm." (Quoted in Biggs 2022c at 13.) The effects of pubertal suppression on future sexual response in females is simply unknown. Professor Biggs cites one observation in which a female in whom puberty was blocked from age 12 to age 16, but who then ceased puberty blockade and did *not* continue to cross-sex hormones, and who nevertheless has experienced no sexual desire in the two years since that cessation. (Biggs 2022c at 13.) In the case of males, the cross-sex administration of estrogen limits penile genital growth and

function. In the case of females, prolonged exposure to exogenous testosterone impairs vaginal function. Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that is ultimately applicable to the transgendered. (Levine 2018 at 6.) At the same time, prolonged exposure of females to exogenous testosterone often increases sexual drive to a distracting degree. It is likely that parents and physicians are uncomfortable discussing any aspects of genital sexual activity with patients.

177. **Cardiovascular harm**: Several researchers have reported that cross-sex hormones increase the occurrence of various types of cardiovascular disease, including strokes, blood clots, and other acute cardiovascular events. (Getahun et al. 2018; Guss et al. 2015; Asscheman et al. 2011.) With that said, I agree with the conclusion of the Endocrine Society committee (like that of the NICE Evidence Review) that: "A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or venous thromboembolism in transgender males. Future research is needed to ascertain the potential harm of hormonal therapies." (Hembree et al. 2017 at 3891.) Future research questions concerning long-term harms need to be far more precisely defined. The question of whether cross-sex hormones are safe for adolescents and young adults cannot be answered by analogies to hormone

replacement therapy in menopausal women (which is not a cross-sex usage). Medicine has answered safety questions for menopausal women in terms of cancer and cardiovascular safety: at what dose, for what duration, and at what age range. The science of endocrine treatment of gender dysphoric youth is being bypassed by short-term clinical impressions of safety even though physicians know that cardiovascular and cancer processes often develop over many years.

178. Further, in contrast to administration for menopausal women, hormones begun in adolescence are likely to be administered for four to six decades. The published evidence of adverse impact, coupled with the lack of data sufficient to reach a firm conclusion, make it irresponsible to assert that cross-sex hormones "are safe."

179. **Harm to family and friendship relationships:** As a psychiatrist, I recognize that mental health is a critical part of health generally, and that relationships cannot be separated from and profoundly impact mental health. Gender transition routinely leads to isolation from at least a significant portion of one's family in adulthood. In the case of a juvenile transition, this will be less dramatic while the child is young, but commonly increases over time as siblings who marry and have children of their own do not wish the transgender individual to be in contact with those children. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often "virtual"

friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals. (Levine 2017 at 5.) My concerns about this are based on decades of observations in my professional work with patients.

180. **Sexual-romantic harms associated with transition:** After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished. When a trans person who passes well reveals his or her natal sex, many potential mates lose interest. When a trans person does not pass well, options are likely further diminished. But regardless of a person's appearance, these adults soon learn that many of their dates are looking for exotic sexual experiences rather than genuinely loving relationships. (Levine 2017 at 5, 13; Levine 2013 at 40; Anzani 2021.)

C. The timing of harms.

181. The multi-year delay between start of hormones and the spike in completed suicide demonstrated by several of the studies discussed in Section VII.B above provide a warning that the safety and beneficence of these treatments cannot be judged based on short-term studies or those that do not continue into adulthood. Similarly, several of the harms would not be expected to manifest until the patients reach at least middle age. For example, stroke or other serious cardiovascular event is a complication that is unlikely to manifest during teen years

even if its likelihood over the patient's lifetime has been materially increased via obesity, lipid abnormalities, and smoking. Regret over sterilization or over an inability to form a stable romantic relationship may occur sooner. Psychological challenges of being a trans adult may become manifest after the medical profession is only doing routine follow up care—or, in many cases, has lost contact with the patient altogether. Because few, if any, clinics in this country are conducting systematic long-term follow-up with their child and adolescent patients, the doctors who counsel, prescribe, or perform hormonal and surgical therapies are unlikely ever to become aware of the later negative life impacts, however severe. These concerns are compounded by the findings in the recent "detransitioner" research that 76% did not inform their clinicians of their detransition. (Littman 2021.)

182. The possibility that steps along the transition and affirmation pathway, while lessening the pain of gender dysphoria in the short term, could lead to additional sources of crippling emotional and psychological pain, are too often not considered by advocates of social transition and not considered at all by the trans child. (Levine 2016 at 243.) Clinicians must distinguish the apparent short-term safety of transitioning from likely or possible long-term consequences, and help the patient or parents understand these implications as well. The young patient may feel, "I don't care if I die young, just as long I get to live as a woman." The mature adult may take a different view. Hopefully, so will the child's physician.

183. Individual patients often pin excessive hope in transition, believing that transition will solve what are in fact ordinary social stresses associated with maturation, or mental health co-morbidities. In this way, transition can prevent them from mastering personal challenges at the appropriate time or directly addressing conditions that require treatment. When the hoped-for "vanishing" of other mental health or social difficulties does not occur, disappointment, distress, and depression may ensue. It is noteworthy that half of the respondents to the larger "detransitioner" survey reported that their transition had not helped the gender dysphoria, and 70% had concluded that their gender dysphoria was related to other issues. (Vandenbussche 2021.) Without the clinical experience of monitoring the psychosocial outcomes of these young patients as they age into adulthood, many such professionals experience no challenge to their affirmative beliefs. But medical and mental health professionals who deliver trans affirmative care for those with previous and co-existing mental health problems have an ethical obligation to inform themselves, and to inform patients and parents, that these dramatic treatments are not a panacea.

184. In sum, whether we consider physical or mental health, science does not permit us to say that either puberty blockers or cross-sex hormones are "safe."

IX. PARENTAL INVOLVEMENT IS ESSENTIAL IN MOST CASES FOR ADEQUATE AND ETHICAL TREATMENT OF A CHILD WHO SUFFERS FROM GENDER DYSPHORIA OR SEEKS SOCIAL TRANSITION.

185. For many reasons, in the large majority of cases, the involvement of one or both parents will be essential to a responsible, adequate, and indeed ethical diagnosis and treatment of a child who is or may be suffering from gender dysphoria or one of the related conditions I have described above. In fact, the only situation in which diagnosing / treating a child without parental involvement would be acceptable is when the child is a ward of the state.

A. Involvement of a mental health professional is necessary for accurate diagnosis and appropriate treatment, and access to a mental health professional ordinarily requires parental involvement.

186. Both the WPATH "Standards of Care" (including Version 8) and the Endocrine Society Guidelines are clear that the involvement of a credentialed MHP is important in assessing, diagnosing, and supporting minors who are experiencing gender dysphoria or similar discomfort.

187. Specifically, the Endocrine Society Guidelines advise that: "decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional," and further note that "[b]ecause of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before,

during, and sometimes also after transitioning." (Hembree et al. 2017 at 3872, 3876.)

188. Yet without parental involvement, schools are not able to send minors to a competent MHP for a comprehensive assessment, diagnosis, and treatment planning, nor the accompanying support that would be required. School policies that pursue social transition of a minor without parental involvement, and, consequently, without the involvement of a MHP, will act to the clear detriment of the minor and, ultimately, to the parents as well. Indeed, such policies both preclude the child from receiving adequate care from a well-informed MHP and result in the child receiving substandard care.

B. Parental involvement is necessary for accurate and thorough diagnosis of the child.

189. Once an appropriate, well-informed MHP is involved, parents remain essential to the diagnostic process. A claim or expression of interest in a transgender identity by a child must be the beginning, not the end, of a careful diagnostic and therapeutic process. The child does not know of his or her pregnancy complications, early bonding experiences, physical challenges and other processes that occurred within the ordinary 4-5 amnestic phase of childhood. It is important for the MHP to learn about these processes and events from the parents. Transgender identification in a child is not a simple, uniform phenomenon; there is no single pathway of development and outcomes governing transgender identity,

nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

190. What can be observed by, for example, a teacher or counselor at school, although important, is only one limited window into the multi-faceted life and psyche of a child. A classroom teacher's perspective emphasizes learning capacities, social interactions, and gender style relative to peers, typically during just one nine-month school year.

191. As a starting point, any child suffering serious tension between his or her reproductive potential, biologically dictated body, and sense of gender identity (or desired gender identity) should have the assistance and support of a skilled mental health professional. A meaningful diagnosis of the child's condition requires a sustained relationship between an MHP, the child, and the parents over time. The work cannot be accomplished in a meeting or two. These necessary processes cannot be substituted for by school professionals, who have an important educational but limited view of their pupil.

192. What the child means by a claim of transgender identity may vary widely depending on age. Younger grade school children have some concept of gender, but they "know" little about sex, about the future meanings and manifestations of male or female, about gender identity, and about the evolution of

all aspects of identity over the course of life. What they know is how they currently feel and think, what they have been told by adults, and what they have observed and unconsciously absorbed from various family members. Their behavioral patterns form the basis of the label of transgendered or the diagnosis of Gender Dysphoria of Childhood. The diagnosis tells nothing about the forces that shaped the child's thinking and behavior, nor does it dictate the need for affirmative care.

193. The child may or may not actually suffer from Gender Dysphoria, and this should be determined.[19] Input from parents is important to evaluating whether a child is suffering from "clinically significant distress or impairment in social, school, or other important areas of functioning." (DSM-5-TR.) Autism, Body Dysphoric Disorder, Gender Non-conformance, Intersex Conditions, Paraphilia, Social Phobia, and Psychosis are to be ruled out as primary conditions by the mental health professional in making the diagnosis of Gender Dysphoria. One of these conditions often co-exist with Gender Dysphoria making complex the determination of the mental health professional. School teachers and counselors, by education, training, and experience are not equipped to consider these conditions and their long-term meanings.

[19] See Shumer et al. 2016b at 7: "The Endocrine Society guidelines recommend that children and adolescents with gender concerns be seen by a mental health professional with training in child and adolescent developmental psychology. The mental health professional should: 1) determine whether the individual fulfills DSM criteria for gender dysphoria; 2) inform the individual with respect to possibilities and limitations of sex reassignment and other treatments; and 3) assess for potential psychological comorbidities."

194. Parents typically have observed the child over his or her entire lifetime, or at least a significant portion of it, and so will have unique insight into whether the child's attraction to a transgender identity is longstanding and stable, or whether it has been abrupt and associated with intensive online (or actual) interaction with transgender "communities." (Levine 2021; Leibowitz & de Vries 2016 at 26.) Further, all children are profoundly influenced by their interactions with family members and how they are regarded and treated by them. The gender atypical child is no exception. (Katz-Wise 2017 at 9.) The MHP evaluator needs to explore the sometimes-secretive inner dynamics of the family. This often requires building of trust between the parents and the MHP.

195. This important dynamic is recognized in Version 7 of the WPATH "Standards of Care," which says that any psychological assessment of children or adolescents: "should include an evaluation of the strengths and weaknesses of family functioning." (WPATH 2012 at 15.) Dr. Edwards-Leeper and Dr. Anderson also recognized this, writing in the Washington Post that: "[t]he approach WPATH recommends is collaborative and aims to provide a developmentally appropriate process that involves the parents and takes the complexities of adolescence into consideration." (Edwards-Leeper & Anderson 2021.) Version 8 of the WPATH "Standards of Care" continues to recommend including parents in the assessment process "in almost all situations" and goes on to emphasize that "including

parent(s)/caregiver(s) in the assessment process to encourage and facilitate increased parental understanding and support of the adolescent may be one of the most helpful practices available." (WPATH 2022 at S58.)

196. In addition, as I detail elsewhere, a large proportion of children (and adults) who present with a transgender identity suffer from identifiable psychiatric co-morbidities. (See Section II.C, II.E.) Regardless of whether these are in any way related to the child's gender identity, it is important that these co-morbidities be identified and that appropriate psychotherapeutic help is obtained for the minor.

197. For many parents, a trans identity may appear to arise "out of the blue" around puberty. They may have been dealing with other "normal" behavioral problems in their child—eating patterns, learning disability, social anxiety, autism, bedwetting, depression, cutting, rebellion against religion, etc. However, the announcement of a new identity may be first problem for which they seek a MHP's evaluation.

198. A child who exhibits or expresses an interest in a transgender identity should be evaluated for psychiatric co-morbidities and for the nature of that form of gender identity. A thorough, careful evaluation of the child, his or her family interactions, and life course, needs to be undertaken thoroughly before social transition is pursued. School may be relied upon to share important information with the MHP about learning capacities, social relationships, and behavioral self-

control, but this information is not a substitute for or an alternative means of psychiatric evaluation.

C. Parental involvement is important for effective psychotherapeutic treatment and support of the child.

199. Theories as to the causes of psychological problems, and how they can best be addressed once identified vary widely. There is, however, a broad consensus on the importance of identifying and addressing the causes of distress regardless of its symptomatic manifestation. This is accomplished via a stable trusting relationship with a MHP who is able to form caring and empathetic relationships with the child and parents. Child-oriented psychotherapists are diverse in how they think about and perform parent guidance and child interventions. (Zucker 2020.)

200. Since the child's sense of gender develops in interaction with his or her parents and the child's own emerging gender roles and relationships, the MHP needs to delve into family, marital, and each parent's relationship patterns with the child. These topics are often referred to as the elements of family dynamics.

201. For a child to perform different gender identities and gender roles at home and at school, including situations where parents are kept in ignorance about his or her current self-concepts, is inherently psychologically unhealthy. No professional medical organization has endorsed such an approach. Parents have a vested interest in the mental health of their child—an interest that is not facilitated

by a school pursuing an entirely different approach to the treatment of their child. A child's experience in such a conflicting environment can consolidate the young person's view of the parents as "the enemy" and increase the anxiety load of the child. Indeed, Version 8 of the WPATH "Standards of Care" notes that in most circumstances "it is extremely helpful for parents/guardians to participate in some capacity in the psychotherapy process involving prepubescent children as family factors are often central to a child's well-being." (WPATH 2022 at S73.)

202. In my experience, many parents are in fact taken aback by their child's announcement of a trans identity. Clinicians are there to help parents and their offspring address the gulf between them. Facilitating a "double life" via school policy is not the path to psychological health for either the minor or the parents.

D. Schools are not equipped to enable and obtain informed consent, nor resolve the complex ethical implications raised by social transition.

203. As I have explained in Section V.B above, social transition in children is a powerful psychotherapeutic intervention that multiple informed observers have warned is likely to reduce the number of children "desisting" from transgender identity. Moreover, as I detailed in Section V.C above, social transition starts a child on a "conveyor belt" path that leads in the vast majority of cases to the administration of puberty blockers, which in turn leads in the vast majority of cases

to the administration of cross-sex hormones – all of which carry known risks. Given these risks, medical and mental health ethics require at least two things before a minor child is placed on the first step of that conveyor belt: (i) informed consent from the parents (as the minor can only provide *assent*), and (ii) concurrence in the decision by an appropriate professional who exercises clinical judgment informed by scientific principles.

204. Schools that socially transition children by, for example, referring to children by a name and pronouns associated with the gender they identify with and allowing the use of opposite-sex bathrooms, without informing or involving their parents, violate these requirements in at least three ways.

205. **First**, children are generally held by law to be cognitively incapable of giving informed consent to life-altering interventions. In my view, this includes affirmative care (including social transition), as minor children have not lived long enough to appreciate each element of the affirmative care and the potential consequences of it. It is the ethical responsibility of the medical professional to inform and to see to it that the parents as well as the child comprehend the various possibilities of harm. This requirement would be subverted by a school policy that provides for school personnel to undertake the social transition of minors without the knowledge or permission of the parents. Moreover, as discussed above, such a policy is detrimental to the psychological wellbeing and treatment of the child

because it necessarily results in the child inhabiting different gender identities and performing different gender roles at home than at school.

206. All mental health professionals are aware that situations occur in which parents act in a manner that might imperil the well-being of their children. This is not the general expectation, however, and it is not assumed. When this is thought to the be the situation, mental health professionals—as well as educators and school counselors—may seek judicial intervention to remove children from their parents' custody. This process is surrounded by procedures and safeguards that, among other things, protect against unnecessary disruption of parental authority and the bond between parents and their children. Educators and school counselors should not undertake the task of secretly treating a child with a trans identity simply because they suspect the parent(s) may not support the child's new sense of self. Absent any indication of harmful conduct by the parent, school staff should not exclude parents from the process.

207. **Second**, educators and generally trained school counselors do not have sufficient knowledge of the complexities and risks in this field to provide the accurate and extensive information that is an essential prerequisite to informed consent. Knowing the uncertainties in this arena of care requires an open, honest, thorough, and informed consent process. (Levine et al. 2022.) Consent without comprehensive information cannot be informed consent. Most commonly,

meaningful engagement with difficult and painful questions involved requires a process that will consist of multiple discussions in a psychotherapeutic or counseling context, not merely "disclosure" of facts. In my experience, a too-rapid or too-eager attachment to some outcome is a warning flag that the patient is not able to tolerate knowledge of the risks and alternative approaches.

208. In my judgment, people who are not trained mental health professionals in the field will not have the knowledge and the training needed to engage in the probing process of informed consent that I have described above—much less to give the child adequate treatment—and few will even be aware of the full implications of this ethical requirement. They may also be unaware of—or even reject—the well-recognized developmental, ethical, and legal limits on the ability of children to grant consent to serious medical or psychotherapeutic interventions. When the clinical experience and areas of competence of even PhD school psychologists are considered, it is usually apparent that their training and professional experiences to date do not equip them to guide parents and children—much less children without parental involvement—through the uncertainties and ethical dilemmas inherent in children and adolescents who are struggling with gender-identity issues or experiencing a sense of transgender identity**.**

209. **Third**, because they do not possess the relevant scientific knowledge, school personnel are not in a position to exercise the separate and independent

judgment that ethical principles would require of a medical or mental health professional. Medical professionals, be they physicians or psychologists, must weigh the risks and benefits of treatment against the benefits and harms of not treating, in the short and in the long term. In medicine as a whole, when in the judgment of the medical professional the risks outweigh the benefits, ethical principles prohibit the treatment. The medical professional may not abdicate or delegate this independent ethical responsibility.

210. The psychiatrist or psychologist treating a child must realize that the goal is not merely to make the child happier now. Rather, it is to make him or her as healthy and happy as possible across the entire trajectory of life, to the extent that is predictable. These matters need to be thoroughly discussed with the parents and MHP, with the parents and child, and with the child and MHP. These discussions when they include information about long term consequences and risks relative to the hoped-for benefits constitutes the processes that create a legal and ethical informed consent. With respect to children, who are not equipped to understand, evaluate, and feel the life implications of such information, it is doubtful that there is any meaningful way in which they can be said to "know" what will make them happy over the long term. It is for similar reasons that parents ordinarily make a great many decisions, both large and small, for their young children.

211. For this reason, it is my opinion that asking a child whether he or she wishes to transition to living as the opposite sex, or giving large weight to the child's expressed wishes by no means satisfies the MHP's ethical obligation to obtain informed consent before assisting that child to transition to living as the opposite sex. Further, social transitioning a child at school, while excluding the parent(s) from the process, based on nothing more than the child's statement that they "feel like" they are the opposite gender (or similar words), even if that statement is repeated over the course of several weeks or months, does not satisfy this requirement, nor does it constitute adequate care.

212. The absence of long-term studies in the arena of childhood gender dysphoria or the more recently documented phenomenon of "rapid onset gender dysphoria" among adolescents means that therapeutic responses to these conditions are still at a primitive stage of development, and must be considered to be experimental, rendering adequately informed consent all the more essential, and all the more difficult to obtain. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine 2016 at 241.)

213. Hence, it is evident that schools do not have the medical, ethical, or legal authority to analyze and resolve these complex issues and proceed to socially transition a child in the school context while keeping the child's trans-

identification secret from the child's parents. Doing such, to make the educational environment "safe and welcoming" for all students, is based on a social or political sensibility. However, such thinking greatly oversimplifies what is at stake for the child and his immediate and extended family now and most certainly in the future. It is my opinion that schools' responsibility is to educate not to unknowingly—and inadequately—practice psychiatric medicine.

Dated: January 4, 2023

Stephen B. Levine

Subscribed and sworn to before me
This 4th day of January, 2023.

Notary Public, State of Ohio
My commission expires 3/9/25

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Zucker, K. (2018). *The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al.* (2018). INTERNATIONAL JOURNAL OF TRANSGENDERISM *19*(2) 231–245.

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LEVINE REPORT

EXHIBIT A

Curriculum Vita
Stephen B. Levine, M.D.

I) **Brief Introduction**

Dr. Levine is Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the solo author of five books, Sex Is Not Simple in 1989 (translated to German in 1992 and reissued in English in 1997 as Solving Common Sexual Problems); Sexual Life: A clinician's guide in 1992; Sexuality in Midlife in 1998 and Demystifying Love: Plain talk for the mental health professional in 2006; Barriers to Loving: A clinician's perspective in 2013; Psychotherapeutic Approaches to Sexual Problems: An Essential Guide for Mental Health Professionals in 2020. He is the Senior Editor of the first (2003), second (2010) and third (2016) editions of the Handbook of Clinical Sexuality for Mental Health Professionals. He has been teaching, providing clinical care, and writing since 1973 and has generated original research, invited papers, commentaries, chapters, and book reviews. He has served as a journal manuscript and book prospectus reviewer for many years. He was co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992-2017. He and two colleagues received a lifetime achievement Masters and Johnson's Award from the Society for Sex Therapy and Research in March 2005. He was given his Department of Psychiatry's Hall of Fame Award in 2021.

II) **Personal Information**

A) Date of birth 1942
B) Medical license no. Ohio 35-03-0234-L
C) Board Certification 6/76 American Board of Neurology and Psychiatry
D) Office-23425 Commerce Park, Beachwood, Ohio 44122-5402 phone 216-831-2900 x 13 fax 216-831-4306, direct dial 216-998-9905

III) **Education**

A) 1963 BA Washington and Jefferson College
B) 1967 MD Case Western Reserve University School of Medicine
C) 1967-68 internship in Internal Medicine University Hospitals of Cleveland
D) 1968-70 Research associate, National Institute of Arthritis and Metabolic Diseases, Epidemiology Field Studies Unit, Phoenix, Arizona, United States Public Health Service
E) 1970-73 Psychiatric Residency, University Hospitals of Cleveland
F) 1974-77 Robert Wood Johnson Foundation Clinical Scholar

IV) **Appointments at Case Western Reserve University School of Medicine**

A) 1973- Assistant Professor of Psychiatry
B) 1979-Associate Professor
C) 1982-Tenure
D) 1985-Full Professor
E) 1993-Clinical Professor

V) **Honors**

A) Summa Cum Laude, Washington & Jefferson
B) Teaching Excellence Award-1990 and 2010 (residency program)
C) Visiting Professorships

1) Stanford University-Pfizer Professorship program (3 days)–1995
2) St. Elizabeth's Hospital, Washington, DC –1998
3) St. Elizabeth's Hospital, Washington, DC--2002

D) Named to America's Top Doctors consecutively since 2001
E) Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research, April 2005 along with Candace Risen and Stanley Althof
F) 2006 SSTAR Book Award for The Handbook of Clinical Sexuality for Mental Health Professionals: Exceptional Merit
G) 2018—Albert Marquis Lifetime Achievement Award from Marquis Who's Who. (excelling in one's field for at least twenty years)
H) Invitations to present various Grand Rounds at Departments of Psychiatry and Continuing Education Lectures and Workshops during 2019-2022
1) March 12, 2021-The Mental Health Professionals' Role with the Transgendered: Making the Controversies Clear Grand Rounds University Hospitals of Cleveland
2) May 1, 2021 Psychotherapeutic Approaches to Sexual Problems Invited lecture to the American Psychiatric Association Annual Meeting (similar lecture in May 2020
3) Seven years of Continuing Education Courses at the American Psychiatric Association Meetings on Love and Sexuality
4) Grand Rounds at Cleveland Clinic Foundation on Sexuality Education of Psychiatric Residents June 25, 2020
5) Grand Rounds at Cleveland Clinic Foundation June 2019 Transgenderism: Beware! Repeated by invitation at Akron General Hospital and at National meeting of American Association of Partial Hospitalization in 2019
6) Three-hour workshop at Society of Sex Therapy and Research in 2020 on Therapy for Sexual Problems
7) Workshop on Teaching Sexuality to residents at the American Association of Residency Training Directors 2020 annual meeting
8) Three-hour continuing education seminar with Massachusetts Department of Corrections Gender Identity Staff Fall 2019
9) Four-hour seminar on Gender Dysphoria at Harvard Student Health Service Staff
10) Three grand rounds presentations at Henry Ford Hospital on Transgender Evaluation and Treatment of Children, Adolescents, and Adults
11) Symposium (90 minutes) at the American Psychiatric Association 2022 meeting The Management of Adolescent-Onset Transgender Identity: Should "Best Practices" Change?

VI) **Professional Societies**

A) 1971- American Psychiatric Association; fellow; #19909
B) 2005-American Psychiatric Association-Distinguished Life Fellow
C) 1973- Cleveland Psychiatric Society
D) 1973-Cleveland Medical Library Association
1) 1985-Life Fellow
2) 2003 Distinguished Life Fellow

E) 1974-Society for Sex Therapy and Research
   1) 1987-89-President
F) 1983- International Academy of Sex Research
G) 1983- Harry Benjamin International Gender Dysphoria Association
   1) 1997-8 Chairman, Standards of Care Committee
H) 1994- 1999 Society for Scientific Study of Sex

VII) **Community Boards**

A) 1999-2002Case Western Reserve University Medical Alumni Association
B) 1996-2001 Bellefaire Jewish Children's Bureau
C) 1999-2001 Physicians' Advisory Committee, The Gathering Place (cancer rehabilitation)

VIII) **Editorial Boards**

A) 1978-80 Book Review Editor Journal Sex and Marital Therapy
B) Manuscript Reviewer for
   1) Archives of Sexual Behavior*
   2) Annals of Internal Medicine
   3) British Journal of Obstetrics and Gynecology
   4) JAMA
   5) Diabetes Care
   6) American Journal of Psychiatry
   7) Maturitas
   8) Psychosomatic Medicine
   9) Sexuality and Disability
   10) Journal of Nervous and Mental Diseases
   11) Journal of Neuropsychiatry and Clinical Neurosciences
   12) Neurology
   13) Journal Sex and Marital Therapy*
   14) Journal Sex Education and Therapy
   15) Social Behavior and Personality: an international journal (New Zealand)
   16) International Journal of Psychoanalysis
   17) International Journal of Transgenderism
   18) Journal of Urology
   19) Journal of Sexual Medicine* named Gold reviewer in 2021
   20) Current Psychiatry
   21) International Journal of Impotence Research
   22) Postgraduate medical journal
   23) Academic Psychiatry
   24) Expert Opinion on Drug Safety
   25) Clinical Psychology Reviews
   26) Heliyon
   27) Andrologia
   28) Children and Youth Services Review
   29) Women and Criminal Justice
   30) Children
   31) European Journal of Child and Adolescent Psychiatry

32) International Journal of Environmental and Public Health
33) Journal of Controversial Ideas
*frequent

C) Book Prospectus Reviewer
1) Guilford
2) Oxford University Press
3) Brunner/Routledge
4) Routledge

IX) **Administrative Responsibilities**

A) Co-director, Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. until June 30, 2017
B) Principal Investigator of approximately 70 separate studies involving pharmacological interventions for sexual dysfunction since 1989.
C) Co-leader of case conferences at DELR. LLC.com
D) Expert Witness Appearances in Depositions or at Trial
1) US District Court, Judge Mark L. Wolf's witness in Michelle Kosilek vs. Massachusetts Dept of Corrections et al. case (transsexual issue) in Boston 2007
2) Deposition in the Battista vs. Massachusetts Dept of Corrections case (transsexual issue) in Cleveland October 2009
3) Witness for Massachusetts Dept. of Corrections in their defense of a lawsuit brought by prisoner Katheena Soneeya. March 22, 2011 Deposition in Boston and October 2018 in Cleveland and 2019 in Boston.
4) Witness for State of Florida vs. Reyne Keohane July 2017
5) Witness for State of North Carolina in 2021 Kadel et al v. Folwell et al No.1:19-cv-00272-LCB-LPA

X) **Consultancy and Educational Contributions**

A) Massachusetts Department of Corrections—evaluation of 12 transsexual prisoners and the development of a Gender Identity Disorders Program for the state prison system. Monthly consultation with the GID treatment team since February 2009 and the GID policy committee since February 2010. Ongoing
B) California Department of Corrections and Rehabilitation; 2012-2015; education, inmate evaluation, commentary on inmate circumstances, suggestions on future policies
C) Virginia Department of Corrections –evaluation of an inmate for management purposes
D) New Jersey Department of Corrections—evaluation of an inmate for management purposes
E) Idaho Department of Corrections—workshop 2016
F) Florida Department of Corrections-workshop 2016 or 2017
G) Ohio-evaluation of a prisoner for management purposes 2015
H) Massachusetts—continuing education seminar for GID clinic staff. 2019

I) Washington State—workshop on Gender Dysphoria for mental health professionals in DOC and evaluation of two women and one male transgender inmate 2018-9
J) Evaluation of trans inmate in Boston, Massachusetts 2022

XI) **Expert Witness Reports, Depositions, or Testimony**

A) Expert Witness report in Charlene Paige Fuller litigation against Massachusetts DOC. 2015
B) NORSWORTHY, Plaintiff, v. JEFFREY BEARD, et al., Defendants. United States District Court, Northern District of California, CaseNo.C14- -00695JST. 2015
C) SHILOH QUINE (a/k/a RODNEY JAMES QUINE), Plaintiff, vs. JEFFREY BEARD; S. PAJONG; D. BRIGHT; J. DUNLAP; J. LEWIS; and DOES 1-30, Defendants. California 2015
D) Pennsylvania legislative testimony. Written submission and live testimony before a committee of the Pennsylvania legislature. March 2020. (Engaged by Pennsylvania Family Institute.)
E) In the Interests of the Younger Children. Expert testimony by deposition and at trial in Dallas, TX. (Engaged by Texas counsel Odeneal & Odeneal.) (Dallas Cty. Dist. Ct. 2019). Testimony at trial
F) Doe v. Madison Metropolitan School District. Expert declaration submitted February 19, 2020, rebuttal declaration submitted August 14, 2020.
G) Hecox v. Idaho. Expert declaration submitted June 4, 2020
H) Testimony to Subcommittee on Health to Pennsylvania legislature in March 2020
I) Claire et. a. v. DMS et. Al November 16, 2020
J) Kadel et al vs. Folwell et al. North Carolina insurance case deposition Septemer 2021
K) Rhys & Lynn Crawford (Washington State). 3/30/2021
L) Tingley v. Washington State.. (W.D. Wa.) 2021
M) Queen (Quincy Bell) vs. Tavistock and Portman Clinics and NHS in High Court of London, Decision handed down on December 1, 2020.
N) IN THE HIGH COURT OF JUSTICE QUEEN'S BENCH DIVISION ADMINISTRATIVE COURT B E T W E E N: THE QUEEN (on the application of) L and Hampshire County Council-2021
O) *Hennessy-Waller v. Snyder, Case No. CV-20-00335-TUC-SHR, 2021 WL 1192842, at *5-6 & n.10 (D. Ariz. Mar. 30, 2021. Supplemental report 2022 (court prevents access because it involves a minor).*
P) Fain v. PEIA. West Virginia Medicaid Case submitted Feb.18, 2022.
Q) B.P.J. v. West Virginia Board of Education, et al.; Case No. 2:21-cv-316 (United States District Court, Southern District of West Virginia IN DEVELOPMENT March 30, 2022--deposition
R) DYLAN BRANDT, et al., v. LESLIE RUTLEDGE, et al., LESLIE RUTLEDGE, et al., No. 4:21-CV-00450-JM Eastern Division of Arkansas, Central Division—deposition May 26, 2022; court testimony 11/28/2022
S) L.E. vs. Lee MD Tenn. No.3:21-cv-00835—deposition August 18, 2022

XII) **Grant Support/Research Studies**

A) TAP–studies of Apomorphine sublingual in treatment of erectile dysfunction

B) Pfizer–Sertraline for premature ejaculation
C) Pfizer–Viagra and depression; Viagra and female sexual dysfunction; Viagra as a treatment for SSRI-induced erectile dysfunction
D) NIH- Systemic lupus erythematosis and sexuality in women
E) Sihler Mental Health Foundation
    1) Program for Professionals
    2) Setting up of Center for Marital and Sexual Health
    3) Clomipramine and Premature ejaculation
    4) Follow-up study of clergy accused of sexual impropriety
    5) Establishment of services for women with breast cancer
F) Alza–controlled study of a novel SSRI for rapid ejaculation
G) Pfizer–Viagra and self-esteem
H) Pfizer- double-blind placebo control studies of a compound for premature ejaculation
I) Johnson & Johnson – controlled studies of Dapoxetine for rapid ejaculation
J) Proctor and Gamble: multiple studies to test testosterone patch for post menopausal sexual dysfunction for women on and off estrogen replacement
K) Lilly-Icos—study of Cialis for erectile dysfunction
L) VIVUS – study for premenopausal women with FSAD
M) Palatin Technologies- studies of bremelanotide in female sexual dysfunction—first intranasal then subcutaneous administration
N) Medtap – interview validation questionnaire studies
O) HRA- quantitative debriefing study for Female partners os men with premature ejaculation, Validation of a New Distress Measure for FSD,
P) Boehringer-Ingelheim- double blind and open label studies of a prosexual agent for hypoactive female sexual desire disorder
Q) Biosante- studies of testosterone gel administration for post menopausal women with HSDD
R) J&J a single-blind, multi-center, in home use study to evaluate sexual enhancement effects of a product in females.
S) UBC-Content validity study of an electronic FSEP-R and FSDS-DAO and usability of study PRO measures in premenopausal women with FSAD, HSDD or Mixed FSAD/HSDD
T) National registry trial for women with HSDD
U) Endoceutics—two studies of DHEA for vaginal atrophy and dryness in post menopausal women
V) Palatin—study of SQ Bremelanotide for HSDD and FSAD
W) Trimel- a double-blind, placebo controlled study for women with acquired female orgasmic disorder.
X) S1 Biopharma- a phase 1-B non-blinded study of safety, tolerability and efficacy of Lorexys in premenopausal women with HSDD
Y) HRA – qualitative and cognitive interview study for men experiencing PE

XIII) **Publications**

A) <u>Books</u>

1) Pariser SR, Levine SB, McDowell M (eds.), Clinical Sexuality, Marcel Dekker, New York, 1985
2) Sex Is Not Simple, Ohio Psychological Publishing Company, 1988
   (a) Translated into German as Angstfreie Sexualitat: Gluck und Erfullung in der Liebe, Wilhelm Heyne Verlag, Muchen, 1992
   (b) Reissued in paperback as: Solving Common Sexual Problems: Toward a Problem Free Sexual Life, Jason Aronson, Livingston, NJ. 1997
3) Sexual Life: A Clinician's Guide. Plenum Publishing Corporation. New York, 1992
   (a) See review in Archives of Sexual Behavior 28(4): 361-363,1999
4) Sexuality in Midlife. Plenum Publishing Corporation. New York, 1998
   (a) See review in Am Journal of Psychiatry 156((9):1468, 1999
   (b) See review in Contemporary Psychology APA Review of Books 44(4):293-295, 1999
   (c) See review J Sex Education and Therapy January, 2000
   (d) See review J Sex and Marital Therapy, Winter, 2000
5) Editor. Clinical Sexuality. Psychiatric Clinics of North America, March, 1995.
6) Editor, (Candace Risen and Stanley Althof, associate editors) Handbook of Clinical Sexuality for Mental Health Professionals. Routledge, New York, 2003
   1. see review American Journal of Psychiatry April, 2005
   2. 2006 SSTAR Book Award: Exceptional Merit
   3. see review in Archives of Sexual Behavior 35(6):757-758
   4. see two reviews in Journal of Sex and Marital Therapy 33(3):272-276
7) Demystifying Love: Plain Talk For The Mental Health Professional. Routledge, New York, 2006
   (a) See review in Psychiatric Times, August 2008 by Leonore Tiefer
   (b) See review in Journal of Sex and Marital Therapy 34(5)-459-460.
8) Senior editor, (Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 2nd edition Routledge, New York, 2010. See review by Pega Ren, JSex&Marital Therapy
9) Barriers to Loving: A Clinician's Perspective. Routledge, New York, 2014.
10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3rd edition Routledge, New York, 2016
11) Psychotherapeutic Approaches to Sexual Problems: An essential guide for mental health professionals, 2020
   (i) See review in J Sex and Marital Therapy

B) Research and Invited Papers When his name is not listed in a citation, Dr. Levine is either the solo or the senior author
   1) Sampliner R. Parotid enlargement in Pima Indians. Annals of Internal Medicine 1970; 73:571-73

2) Confrontation and residency activism: A technique for assisting residency change: World Journal of Psychosynthesis 1974; 6: 23-26
3) Activism and confrontation: A technique to spur reform. Resident and Intern Consultant 173; 2
4) Medicine and Sexuality. Case Western Reserve Medical Alumni Bulletin 1974:37:9-11.
5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334
6) Marital Sexual Dysfunction: Introductory Concepts. Annals of Internal Medicine 1976;84:448-453
7) Marital Sexual Dysfunction: Ejaculation Disturbances . Annals of Internal Medicine 1976; 84:575-579
8) Yost MA: Frequency of female sexual dysfunction in a gynecology clinic: An epidemiological approach. Archives of Sexual Behavior 1976;5:229-238
9) Engel IM, Resnick PJ, Levine SB: Use of programmed patients and videotape in teaching medical students to take a sexual history. Journal of Medical Education 1976;51:425-427
10) Marital Sexual Dysfunction: Erectile dysfunction. Annals of Internal Medicine 1976;85:342-350
11) Articles in Medical Aspects of Human Sexuality
    (a) Treating the single impotent male. 1976; 10:123, 137
    (b) Do men enjoy being caressed during foreplay as much as women do? 1977; 11:9
    (c) Do men like women to be sexually assertive? 1977;11:44
    (d) Absence of sexual desire in women: Do some women never experience sexual desire? Is this possibility genetically determined? 1977; 11:31
    (e) Barriers to the attainment of ejaculatory control. 1979; 13:32-56.
    (f) Commentary on sexual revenge.1979;13:19-21
    (g) Prosthesis for psychogenic impotence? 1979;13:7
    (h) Habits that infuriate mates. 1980;14:8-19
    (i) Greenberger-Englander, Levine SB. Is an enema an erotic equivalent?1981; 15:116
    (j) Ford AB, Levine SB. Sexual Behavior and the Chronically Ill Patients. 1982; 16:138-150
    (k) Preoccupation with wife's sexual behavior in previous marriage 1982; 16:172
    (l) Co-existing organic and psychological impotence. 1985;19:187-8
    (m) Althof SE, Turner LA, Kursh ED, Bodner D, Resnick MI, Risen CB. Benefits and Problems with Intracavernosal injections for the treatment of impotence. 1989;23(4):38-40
12) Male Sexual Problems. Resident and Staff Physician 1981:2:90-5
13) Female Sexual Problems. Resident and Staff Physician 1981:3:79-92

14) How can I determine whether a recent depression in a 40 year old married man is due to organic loss of erectile function or whether the depression is the source of the dysfunction? Sexual Medicine Today 1977;1:13
15) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977
16) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597
17) Current problems in the diagnosis and treatment of psychogenic impotence. Journal of Sex & Marital Therapy 1977;3:177-186
18) Resnick PJ, Engel IM. Sexuality curriculum for gynecology residents. Journal of Medical Education 1978; 53:510-15
19) Agle DP. Effectiveness of sex therapy for chronic secondary psychological impotence Journal of Sex & Marital Therapy 1978;4:235-258
20) DePalma RG, Levine SB, Feldman S. Preservation of erectile function after aortoiliac reconstruction. Archives of Surgery 1978;113-958-962
21) Conceptual suggestions for outcome research in sex therapy Journal of Sex & Marital Therapy 1981;6:102-108
22) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113
23) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929
24) Stern RG Sexual function in cystic fibrosis. Chest 1982; 81:422-8
25) Shumaker R. Increasingly Ruth: Towards understanding sex reassignment surgery Archives of Sexual Behavior 1983;12:247-61
26) Psychiatric diagnosis of patients requesting sex reassignment surgery. Journal of Sex & Marital Therapy 1980; 6:164-173
27) Problem solving in sexual medicine I. British Journal of Sexual Medicine 1982;9:21-28
28) A modern perspective on nymphomania. Journal of Sex & Marital Therapy 1982;8:316-324
29) Nymphomania. Female Patient 1982;7:47-54
30) Commentary on Beverly Mead's article: When your patient fears impotence. Patient Care 1982;16:135-9
31) Relation of sexual problems to sexual enlightenment. Physician and Patient 1983 2:62
32) Clinical overview of impotence. Physician and Patient 1983; 8:52-55.
33) An analytical approach to problem-solving in sexual medicine: a clinical introduction to the psychological sexual dysfunctions. II. British Journal of Sexual Medicine
34) Coffman CB, Levine SB, Althof SE, Stern RG Sexual Adaptation among single young adults with cystic fibrosis. Chest 1984;86:412-418
35) Althof SE, Coffman CB, Levine SB. The effects of coronary bypass in female sexual, psychological, and vocational adaptation. Journal of Sex & Marital Therapy 1984;10:176-184

36) Letter to the editor: Follow-up on Increasingly Ruth. Archives of Sexual Behavior 1984;13:287-9
37) Essay on the nature of sexual desire Journal of Sex & Marital Therapy 1984; 10:83-96
38) Introduction to the sexual consequences of hemophilia. Scandanavian Journal of Haemology 1984; 33:(supplement 40).75-
39) Agle DP, Heine P. Hemophila and Acquired Immune Deficiency Syndrome: Intimacy and Sexual Behavior. National Hemophilia Foundation; July, 1985
    (a) Translated into German
    (b) Translated into Spanish
40) Turner LA, Althof SE, Levine SB, Bodner DR, Kursh ED, Resnick MI. External vacuum devices in the treatment of erectile dysfunction: a one-year study of sexual and psychosocial impact. Journal of Sex & Marital Therapy
41) Schein M, Zyzanski SJ, Levine SB, Medalie JH, Dickman RL, Alemagno SA. The frequency of sexual problems among family practice patients. Family Practice Research Journal 1988; 7:122-134
42) More on the nature of sexual desire. Journal of Sex & Marital Therapy 1987;13:35-44
43) Waltz G, Risen CB, Levine SB. Antiandrogen treatment of male sex offenders. Health Matrix 1987; V.51-55.
44) Lets talk about sex. National Hemophilia Foundation January, 1988
45) Sexuality, Intimacy, and Hemophilia: questions and answers . National Hemophilia Foundation January, 1988
46) Prevalence of sexual problems. Journal Clinical Practice in Sexuality 1988;4:14-16.
47) Kursh E, Bodner D, Resnick MI, Althof SE, Turner L, Risen CB, Levine SB. Injection Therapy for Impotence. Urologic Clinics of North America 1988; 15(4):625-630
48) Bradley SJ, Blanchard R, Coates S, Green R, Levine S, Meyer-Bahlburg H, Pauly I, Zucker KJ. Interim report of the DSM-IV Subcommittee for Gender Identity Disorders. Archives of Sexual Behavior 1991;;20(4):333-43.
49) Sexual passion in mid-life. Journal of Clinical Practice in Sexuality 1991 6(8):13-19
50) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DR, Resnick MI. Intracavernosal injections in the treatment of impotence: A prospective study of sexual, psychological, and marital functioning. Journal of Sex & Marital Therapy 1987**;** 13:155-167
51) Althof SE, Turner LA, Risen CB, Bodner DR, Kursh ED, Resnick MI. Side effects of self-administration of intracavernosal injection of papaverine and phentolamine for treatment of impotence. Journal of Urology 1989;141:54-7

52) Turner LA, Froman SL, Althof SE, Levine SB, Tobias TR, Kursh ED, Bodner DR. Intracavernous injection in the management of diabetic impotence. Journal of Sexual Education and Therapy 16(2):126-36, 1989
53) Is it time for sexual mental health centers? Journal of Sex & Marital Therapy 1989**;**
54) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Sexual, psychological, and marital impact of self injection of papaverine and phentolamine: a long-term prospective study. Journal of Sex & Marital Therapy
55) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Why do so many men drop out of intracavernosal treatment? Journal of Sex & Marital Therapy. 1989;15:121-9
56) Turner LA, Althof SE, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Self injection of papaverine and phentolamine in the treatment of psychogenic impotence. Journal of Sex & Marital Therapy. 1989; 15(3):163-78
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E) Podcasts

1) Ayad & O'Malley, series: Gender: A wider lens. 2022 https://podcasts.apple.com/us/podcast/gender-a-wider-lens-podcast/id1542655295?i=1000549259922

2) Physician burnout 2022 https://drive.google.com/drive/folders/1O5ENno71IzKtYslhyZfqja4SrV5lQcic?usp=sharing

EXHIBIT B

Our Schools

Type a name, or keyword, to search the school listing

All Sites | All Groups | All Education Levels

Academy For Change (AFC - Community Day)

OTHER

290 East Avenue
Chico, CA 95926

SCHOOL INFO | 5308913092

VISIT WEBSITE

Bidwell Junior High School

MIDDLE SCHOOL

2376 North Avenue
Chico, CA 95926

SCHOOL INFO | 5308913080

VISIT WEBSITE

Center For Alternative Learning (CAL)

MIDDLE SCHOOL

290 East Avenue
Chico, CA 95926

SCHOOL INFO | 5308913092

VISIT WEBSITE

Chapman Elementary School

ELEMENTARY SCHOOL

1071 East 16th Street
Chico, CA 95928

SCHOOL INFO | 5308913100

VISIT WEBSITE

Chico High School

HIGH SCHOOL

901 Esplanade, Chico, CA 95926
Chico, CA 95926

SCHOOL INFO | 530.891.3026

VISIT WEBSITE

Chico Junior High School

MIDDLE SCHOOL

280 Memorial Way
Chico, CA 95926

SCHOOL INFO | (530) 891-3066

VISIT WEBSITE

Chico Unified School District

DISTRICT OFFICE

1163 East Seventh Street
Chico, CA 95928

SCHOOL INFO | (530) 891-3000

VISIT WEBSITE

Citrus Elementary

ELEMENTARY SCHOOL

1350 Citrus Avenue
Chico, CA 95926

SCHOOL INFO | 5308913107

VISIT WEBSITE

Emma Wilson Elementary

ELEMENTARY SCHOOL

1530 West 8th Avenue
Chico, CA 95926

SCHOOL INFO | 5308913297

VISIT WEBSITE

Fair View High School

HIGH SCHOOL

290 East Avenue
Chico, CA 95926

SCHOOL INFO | 5308913092

VISIT WEBSITE

Hooker Oak Elementary School

ELEMENTARY SCHOOL

1238 Arbutus Ave
Chico, CA 95926

SCHOOL INFO | (530) 891-3119

VISIT WEBSITE

Little Chico Creek Elementary

ELEMENTARY SCHOOL

2090 Amanda Way
Chico, CA 95928

SCHOOL INFO | 5308913285

VISIT WEBSITE

Loma Vista (Special Services Program)**

HOME

1580 Marcum Avenue
Chico, CA 95926

SCHOOL INFO | 5308797400

VISIT WEBSITE

Marigold School

ELEMENTARY SCHOOL

2446 Marigold
Chico, CA 95926

SCHOOL INFO | 5308913121

VISIT WEBSITE

Marsh Junior High School

MIDDLE SCHOOL

2253 Humboldt Road
Chico, CA 95928

SCHOOL INFO | 5308954110

VISIT WEBSITE

McManus Elementary School

ELEMENTARY SCHOOL

988 East Avenue
Chico, CA 95926

SCHOOL INFO | 5308913128

VISIT WEBSITE

Neal Dow Elementary School

ELEMENTARY SCHOOL

1420 Neal Dow
Chico, CA 95926

SCHOOL INFO | 5308913110

VISIT WEBSITE

Oak Bridge Academy (Online Learning)

OTHER

1350 E. Lassen Ave.
Chico, CA 95973

SCHOOL INFO | 5308978877

CONTACT | VISIT WEBSITE

Oakdale (Independent Study)

OTHER

290 East Avenue, Chico, CA 95926
Chico, CA 95926

SCHOOL INFO | (530)891-3092

VISIT WEBSITE

Parkview Elementary School

ELEMENTARY SCHOOL

1770 East Eighth Street
Chico, CA 95928

SCHOOL INFO | (530) 891-3114

VISIT WEBSITE

Pleasant Valley High School

HIGH SCHOOL

1475 East Avenue
Chico, CA 95926

SCHOOL INFO | 530-891-3050

VISIT WEBSITE

Rosedale Elementary

ELEMENTARY SCHOOL

100 Oak Street
Chico, CA 95928

SCHOOL INFO | 5308913104

VISIT WEBSITE

Shasta Elementary School

ELEMENTARY SCHOOL

169 Leora Court
Chico, CA 95928

SCHOOL INFO | 5308913141

VISIT WEBSITE

Sierra View Elementary School

ELEMENTARY SCHOOL

1598 Hooker Oak Avenue
Chico, CA 95926

SCHOOL INFO | 5308913117

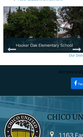
VISIT WEBSITE

Please Note

* Preschool Program is Limited. Learn More.
** Special Services School. Learn More

Additional Information

- Kindergarten Registration
- New Student Enrollment



Hooker Oak Elementary School

CHICO UNIFIED SCHOOL DISTRICT

1163 East Seventh Street,
Chico, CA 95928-5999

(530) 891-3000
(530) 891-3220

ACCESSIBILITY | REPORT ISSUES | WEBMAIL | STAFF ROOM | ADMIN STAFF LOGIN | IT SUPPORT
HBO WORK ORDER

EXHIBIT C

Chico Unified School District

Board Agenda | Directory | Departments | Student/Par...

OUR DISTRICT | SCHOOLS | PROGRAMS | SERVING YOU | NEWS | CONTACT US

Our District

Chico Unified School District (CUSD) is located in California's lush Sacramento Valley and covers 322 square miles. CUSD oversees 23 schools: *12 Elementary; three Junior High; two High School; one Continuation (FVHS); one Community Day School (AFC); one Opportunity (CAL); one Independent Study (Oakdale); one Special Services (Loma Vista); one Online Learning Academy (Oak Bridge Academy); four Preschool Programs.*

Every school site strives to offer a diverse curriculum, highly qualified teachers and a dedicated staff placing students at the forefront of the learning process.

History of Chico Unified - Chico's first public school dates back to 1865; Salem Street School opened with a temporary roof and wooden floors. An entire public school system grew from these first humble beginnings.

In 1965, a special election was called and Chico Unified School District was formed.

Since its inception, Chico Unified School District has grown to encompass 18 schools with over 12,000 students and is comprised of many unique programs such as: preschool, transitional kindergarten (TK), continuation school, community day school, independent study program, Career and Technical Education programs (CTE), special services and an online academy.

We value our community partners and all of Chico for making public education a priority.

Quick Links

Chico Unified School District
(530) 891-3000

- LCAP
- SARC Reports

Are you a student, parent, or community member? Keep in touch with us:

Facebook | Twitter | Instagram | Youtube

CHICO UNIFIED SCHOOL DISTRICT

1163 East Seventh Street,
Chico, CA 95928-5999

(530) 891-3000
(530) 891-3220

EXHIBIT D

Chico Unified School District

Board Information - CUSD Board of Education

The Governing Board consists of five members elected during statewide primary or general elections. Board Members serve a term of four years in office. The Board operates under the authority of the California Constitution, State Legislature, California Education Code and the California State Board of Education. The trustees are responsible for oversight, policy and adopting the annual Chico Unified School District Local Control and Accountability Plan which serves as the foundation for district-wide goals and priorities.

The Board of Education welcomes the opportunity to connect with parent, teachers and staff.

Meet the Board Members

DALBY, CAITLIN

BOARD MEMBER - AT LARGE

(530) 891-3000 x20235

SEND MESSAGE

Dept: Board of Education

KONKIN, REBECCA

BOARD MEMBER - TRUSTEE AREA 1

(530) 891-3000 x20149

SEND MESSAGE

Dept: Board of Education

LANDO, TOM

BOARD MEMBER - TRUSTEE AREA 4

(530) 891-3000 x20235

SEND MESSAGE

Dept: Board of Education

ROBINSON, EILEEN

BOARD MEMBER - TRUSTEE AREA 5

(530) 891-3000 x20235

SEND MESSAGE

Dept: Board of Education

TENNIS, MATT

BOARD MEMBER - AT LARGE

(530) 891-3000 x20235

SEND MESSAGE

Dept: Board of Education

Board of Education
Superintendent's Office
(530) 891-3000 ext. 20149

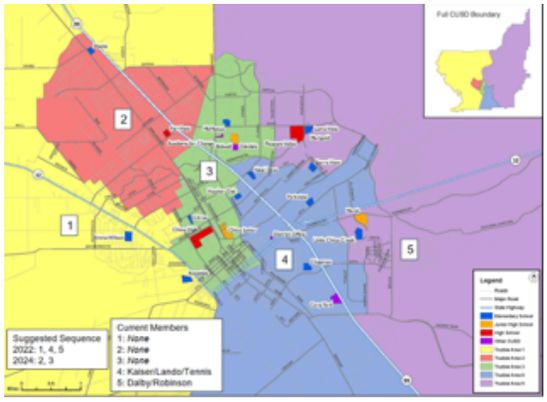
QUICK LINKS

- CUSD Trustee Area Election Maps
- Regularly Scheduled Meeting Calendar
- Meeting Agendas/Minutes
- Contact the Board Trustees
- CUSD Board Policies
- YouTube (Recorded Meetings & Livestream)

Board Agenda Notification

If you are interested in receiving Board Agendas directly to your inbox, please subscribe to our Board Agenda Notification List: **https://bit.ly/3HxYGO2**

Regular meeting agendas are posted 72 hours in advance of the Board Meeting.



Transition to Trustee Area Elections

During the March 09, 2022 Regular Board of Education Meeting, the Board approved Resolution No. 1570-22 Establishing District Based Elections, the Final Map for those Elections and the Sequence for those Elections.

Learn More

Board Materials & Information

Board Meeting Calendar

Upcoming Board Meetings & Calendars

View the calendar of upcoming Board Meetings and Workshops. Board agendas will be posted 72 hours before the meeting.

Learn More

Board Workshops

View Board Workshops & Annual Presentations

Board Liaisons meet with staff prior to a Board Workshop to provide input into the Board presentation. Board Trustees approve the schedule for the upcoming school year each summer.

Learn More

Meeting Agendas

Board Meeting Agendas & Approved Meeting Minutes

View current and past

Board Policies

View All Board Policies for Chico Unified School

Board Meeting Agendas and the accompaning meeting minutes.

Learn More

Board Meeting YouTube Channel

View past Board Meetings and watch the Board Meeting as it is livestreamed.

Watch Now

How to Contact the Board Trustees

The Board Trustees welcome your input. Learn how to connect with members of the Board.

Learn More

District

In order to govern effectively, Districts are required to have accurate and up-to-date Board Policies. By law, Districts are mandated to adopt many policies to ensure legal compliance.

Learn More

Questions or Assistance

Please contact the Superintendent's Office at 530-891-3000 ext. 20149 should you have any questions or require assistance (or disability-related modification or accommodation or Interpreter Services in order to participate in the meeting).

Email Now

The Board Welcomes Your Comments in Writing

The public is encouraged to submit written comments to the Board Members in advance for their prior consideration. **In order to help ensure Board Members have sufficient time to review all comments, please submit comments by noon, on Monday (*two days prior to Wednesday's meeting*).**

Comments should be submitted to the CUSD mailbox at:PublicComment@chicousd.org.

All public comments received by the deadline will be available from the Chico Unified School District Office. The following information should be included in the body of the email:

- Agenda Item Number or
- General Public Comment for Items From the Floor ("Items from the Floor" is an agenda item on the **Regular** Board of Education Meetings – *not Special Board Meetings or Workshops*)

Letters to the Board may be addressed to:

CUSD Board of Education

1163 E. 7th Street
Chico, CA 95928

For additional information/questions, email here or call 530-891-3000, ext. 20149, weekdays, 8:00 a.m. - 4:30 p.m.

Monthly Meetings

Regular Board Meetings | **Special Board Meetings/Workshops**

Regular Board Meetings are typically held the third Wednesday of the month*.

Regular Board of Education Meetings*

When: Third Wednesday of the Month *(some exceptions apply)*
Time: Open Session 6 p.m. *(Closed Session 5 p.m.)*
Location: Marigold School, Multi-Purpose Room, 2446 Marigold Ave., Chico

** Please note: meeting location, time or dates may change. Please refer to the CUSD online calendar and the online agenda for information regarding upcoming meetings.*

Public participation for items not on the agenda are allowed at Regular Board Meetings only. View the Board Meeting agenda for additional details.

Board Related Materials

Resources | **Brown Act Basics** | **Contacts & Meeting Information**

- View Current Board Agendas *(Gamut Online: 1/15/20 - Present)*
- View Past Board Agendas *(Agenda Online: 8/16/17 - 12/18/19)*
- Approved Meeting Minutes *(2019 and earlier)*
- View Board Policies
- Goals & Mission
- 2021-22 Governance Handbook
- Board Meeting Procedures and Conduct
- Live Stream Regular Board Meetings Online
- 2021-22 Board Workshop Topics & Annual Presentations
- 2021 Board Meeting Calendar
- Watch Regular Board Meeting Video Archives

STATEMENT OF NON-DISCRIMINATION: The Governing Board of Chico Unified School District is committed to providing a working and learning environment free from discrimination, harassment, intimidation, and bullying. Chico Unified School District prohibits unlawful discrimination, including discriminatory harassment, intimidation, and bullying, targeted at any student by anyone, based on the student's actual or perceived age, ancestry, ethnicity, parental status, pregnancy status, color, mental or physical disability, gender, gender identity, gender expression, genetic information, immigration status, marital status, medical information, nationality, race, religion, sex, sexual orientation, , or association with a person or group with one or more of these actual or perceived characteristics.

If you believe you, or your student, have been subjected to discrimination, harassment, intimidation, or bullying you should contact your school site principal and/or the District's Chief Compliance and Title IX Officer, Tina Keene, by phone at (530) 891-3000 ext. 20105, by email at kkeene@chicousd.org, or in person at the District Office - 1163 East Seventh Street, Chico, CA 95928.

AMERICANS WITH DISABILITIES ACT: Please contact the Superintendent's Office at 891-3000, ext. 20149 should you require a disability-related modification or accommodation in order to participate in meetings or visit the district office. This request should be received at least 48 hours prior to the meeting in order to accommodate your request. Thank you!

Contact Us with Board Meeting Questions

Name *: Your Name

Email *: Your Email

Email Me a Copy

Subject *: Email Subject

Message *:

I'm not a Robot.

Send

Are you a student, parent, or community member? Keep in touch with us:

Facebook Twitter Instagram Youtube

CHICO UNIFIED SCHOOL DISTRICT

1163 East Seventh Street,
Chico, CA 95928-5999

(530) 891-3000
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EXHIBIT E

Chico Unified School District

Superintendent's Office

EVERY STUDENT EVERY DAY

CADA ESTUDIANTE CADA DÍA

Welcome –

My name is Kelly Staley and I am proud to serve the Chico Community as Superintendent of Chico Unified School District.

Chico Unified is fortunate to be surrounded by a community who fully embraces education from Pre-Kindergarten through high school and beyond. This support has allowed us to focus on our number one priority – our students.
This commitment to the success of every student has led to our schools, staff, and students receiving local, state and national recognition. We are proud to have 12 California Distinguished Schools within our district. These are a testament to our focus on quality teachers and high levels of academic and personal success.

We understand students and parents want choice as education is not one-size-fits-all. CUSD offers a variety of academic programs, learning styles, special and alternative education options, some smaller classroom environments, arts and music, athletics, robotics and career tech classes where students can excel and thoroughly enjoy their educational experience. Our goal is to have students graduate prepared for where life takes them whether it be college, career tech training, the work force, or the military.

To meet the challenges of a rapidly changing world, CUSD is incorporating the latest technology into our instructional programs. Through the additional support and generosity of local businesses, our goal of providing cutting edge technology and instruction can and is becoming a reality.

Thanks to the support of our community through local bonds, CUSD facilities have (and are) undergoing upgrades and improvements physically, technologically and aesthetically, while keeping sustainability in the forefront. New buildings at Pleasant Valley High, Chico High, Chico Jr. High and Marsh Jr. High are just a few examples of recent projects improving the experience of thousands of students throughout the district.

As a commitment to our students' whole being, we have adopted and developed programs focused on nutrition for healthy bodies, physical and psychological health, bullying, and learning challenges. Music and art are once again strong in our schools as are interscholastic athletics. These combine to help create well rounded, productive and educated citizens.

I am proud of our excellent schools, teachers, staff and the growing choices students are offered. I invite you to be a partner in our schools and welcome your participation in our school community. Please feel free to contact me at (530) 891-3000 x 20149 or by email (kstaley@chicousd.org).

Superintendent's Update

Every month we enjoy highlighting the successes and programs our incredible staff and administrators are creating for our students. Learn about our community partnerships and school district updates in the Superintendent's Update.

Click Here

Superintendent's Office
(530) 891-3000 ext. 20235

Subscribe to the Newsletter

Kelly Staley, Superintendent
kstaley@chicousd.org

Quick Links

- Board of Educations Trustees
- Board Meeting Information
- Chico Unified Organizational Chart

EXHIBIT F

Frequently Asked Questions

School Success and Opportunity Act (Assembly Bill 1266) Frequently Asked Questions.

Consistent with our mission to provide a world-class education for all students, from early childhood to adulthood, the California Department of Education issues the following Frequently Asked Questions (FAQs) in an effort to (a) foster an educational environment that is safe and free from discrimination for all students, regardless of sex, sexual orientation, gender identity, or gender expression, and (b) assist school districts with understanding and implementing policy changes related to AB 1266 and transgender student privacy, facility use, and participation in school athletic competitions.

These FAQs are provided to promote the goals of reducing the stigmatization of and improving the educational integration of transgender and gender nonconforming students, maintaining the privacy of all students, and supporting healthy communication between educators, students, and parents to further the successful educational development and well-being of every student.

Expand All | Collapse All

1. What is Assembly Bill (AB) 1266?

AB 1266, also known as the "School Success and Opportunity Act," was introduced by Assemblyman Tom Ammiano on February 22, 2013. It requires that pupils be permitted to participate in sex-segregated school programs, activities, and use facilities consistent with their gender identity, without respect to the gender listed in a pupil's records. AB 1266 was approved by Governor Brown on August 12, 2013.

According to Assemblyman Ammiano, "This bill is needed to ensure that transgender students are protected and have the same opportunities to participate and succeed as all other students." "AB 1266 clarifies California's student nondiscrimination laws by specifying that all students in K-12 schools must be permitted to participate in school programs, activities, and facilities in accordance with the student's gender identity."

As part of the analysis of AB 1266, Assemblyman Ammiano also stated, "Athletics and physical education classes, which are often segregated by sex, provide numerous well-documented positive effects for a student's physical, social, and emotional development. Playing sports can provide student athletes with important lessons about self-discipline, teamwork, success, and failure, as well as the joy and shared excitement that being a member of a sports team can bring. When transgender students are denied the opportunity to participate in physical education classes in a manner consistent with their gender identity, they miss out on these important benefits and suffer from stigmatization and isolation. In addition, in many cases, students who are transgender are unable to get the credits they need to graduate on time when, for example, they do not have a place to get ready for gym class."

2. When did this law go into effect?

AB 1266 became a provision within California Education Code, Section 221.5(f), on January 1, 2014. It is important to note that prior to the enactment of AB 1266, both state and federal law have prohibited gender-based discrimination for some time.

Federal Protection:

Title IX prohibits sexual harassment and discrimination based on gender or sex stereotypes in every jurisdiction. While Title IX does not specifically use the terms "transgender" or "gender identity or expression," courts have held that harassment and other discrimination against transgender and gender nonconforming people constitutes sex discrimination. This position has also been supported by the U.S. Department of Education. These rights were clarified in the October 26, 2010, "Dear Colleague Letter" and the April 29, 2014, guidance issued by the U.S. Department of Education, Office for Civil Rights, described in the "Recent Developments and Resources" section at the end of this document.

California Law:

It is the policy of the State of California to afford all persons in public schools, regardless of their disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code, equal rights and opportunities in the educational institutions of the state. (Education Code Section 200.)

No person shall be subjected to discrimination on the basis of disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code in any program or activity conducted by an educational institution that receives, or benefits from, state financial assistance or enrolls pupils who receive state student financial aid. (Education Code Section 220.)

3. What specifically does AB 1266 provide?

Pre-existing state law prohibits public schools from discriminating on the basis of several characteristics, including sex, sexual orientation, and gender identity. Pre-existing state law also requires that participation in a particular physical education activity or sport, if required of pupils of one sex, be available to pupils of each sex. AB 1266 requires a pupil be permitted to participate in sex-segregated school programs, activities, and facilities including athletic teams and competitions, consistent with his or her gender identity, regardless of the gender listed on the pupil's records.

As amended, Education Code Section 221.5(f) provides that "a pupil shall be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with his or her gender identity, irrespective of the gender listed on the pupil's records."

4. How should a school district, teacher, school administrator or other employee define gender, transgender, or gender identity?

There are a number of developing terms used to describe transgender characteristics and experiences, which may differ based on region, age, culture, or other factors. Many of these terms are not currently defined by law. However, several common definitions have been used by the courts, the U.S. Department of Education, and a number of groups with educational equity expertise, including the Gay, Lesbian, Straight, Education Network, and the California School Boards Association. Any definitions provided in these materials are provided to facilitate the process of providing safe and nondiscriminatory learning environments and are not provided for the purpose of labeling any students.

"Gender" means sex, and includes a person's gender identity and gender expression. "Gender expression" means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth. (*Education Code* Section 210.7.)

"Gender identity" refers to a person's gender-related identity, appearance or behavior whether or not different from that traditionally associated with the person's physiology or assigned sex at birth.

"Gender expression" refers to external cues that one uses to represent or communicate one's gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics.

"Transgender" describes people whose gender identity is different from that traditionally associated with their assigned sex at birth. "Transgender boy" and "transgender male" refer to an individual assigned the female sex at birth who has a male gender identity. "Transgender girl" and "transgender female" refer to an individual assigned the male sex at birth who has a female gender identity. An individual can express or assert a transgender gender identity in a variety of ways, which may but do not always include specific medical treatments or procedures. Medical treatments or procedures are not considered a prerequisite for one's recognition as transgender.

"Gender nonconformity" refers to one's gender expression, gender characteristics, or gender identity that does not conform to gender stereotypes "typically" associated with one's legal sex assigned at birth, such as "feminine" boys, "masculine" girls and those who are perceived as androgynous. Sexual orientation is not the same as gender identity. Not all transgender youth identify as gay, lesbian or bisexual, and not all gay, lesbian and bisexual youth display gender-nonconforming characteristics.

5. How can a teacher or school administrator determine whether a student is transgender or not?

The first and best option is always to engage in an open dialogue with the student and the student's parent or parents if applicable (but see FAQs 6 and 7). Gender identity is a deeply rooted element of a person's identity. Therefore, school districts should accept and respect a student's assertion of their gender identity where the student expresses that identity at school or where there is other evidence that this is a sincerely held part of the student's core identity. Some examples of evidence that the student's asserted gender identity is sincerely held could include letters from family members or healthcare providers, photographs of the student at public events or family gatherings, or letters from community members such as clergy.

If a student meets one or more of those requirements, a school may not question the student's assertion of their gender identity except in the rare circumstance where school personnel have a credible basis for believing that the student is making that assertion for some improper purpose. The fact that a student may express or present their gender identity in different ways in different contexts does not, by itself, undermine a student's assertion of their gender identity.

A school cannot require a student to provide any particular type of diagnosis, proof of medical treatment, or meet an age requirement as a condition to receiving the protections afforded under California's antidiscrimination statutes. Similarly, there is no threshold step for social transition that any student must meet in order to have his or her gender identity recognized and respected by a school.

6. May a student's gender identity be shared with the student's parents, other students, or members of the public?

A transgender or gender nonconforming student may not express their gender identity openly in all contexts, including at home. Revealing a student's gender identity or expression to others may compromise the student's safety. Thus, preserving a student's privacy is of the utmost importance. The right of transgender students to keep their transgender status private is grounded in California's antidiscrimination laws as well as federal and state laws. Disclosing that a student is transgender without the student's permission may violate California's antidiscrimination law by increasing the student's vulnerability to harassment and may violate the student's right to privacy.

- A. Public Records Act requests - The Education Code requires that schools keep student records private. Private information such as transgender status or gender identity falls within this code requirement and should not be released. (Education Code Section 49060.)
- B. Family Educational and Privacy Rights (FERPA) - FERPA is federal law that protects the privacy of students' education records. FERPA provides that schools may only disclose information in school records with written permission from a student's parents or from the student after the student reaches the age of 18. (20 U.S.C. Section 1232g.) This includes any "information that . . . would allow a reasonable person in the school community . . . to identify the student with reasonable certainty." (34 C.F.R. Section 99.3.)
- C. California Constitution - Minors enjoy a right to privacy under Article I, Section I of the California Constitution that is enforceable against private parties and government officials. The right to privacy encompasses the right to non-disclosure (autonomy privacy) as well as in the collection and dissemination of personal information such as medical records and gender identity (informational privacy). Even when information is part of a student's records and therefore covered by FERPA, the law provides several exceptions that permit appropriate communications under circumstances in which the student or others may be at risk of harm. Transgender or gender nonconforming students are often subject to stressors which can place them at risk of self-harm. FERPA expressly permits the disclosure of information from a student's records "…to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals." (34 C.F.R. Section 99.36(a).) "If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals." *(Id.* Section 99.36(c).)

Moreover, although FERPA restricts disclosures of information obtained from a student's records, it was never intended to act as a complete prohibition on all communications. One threshold point that is often overlooked is that FERPA limits only the disclosure of records and information from records about a student. It does not limit disclosure or discussion of personal observations.

In other words, if a school employee develops a concern about a student based on the employee's observations of or personal interactions with the student, the employee may disclose that concern to anyone without violating, or even implicating, FERPA. Of course, in most cases, the initial disclosure should be made to professionals trained to evaluate and handle such concerns, such as school student health or welfare personnel, who can then determine whether further and broader disclosures are appropriate.

7. What steps should a school or school district take to protect a transgender or gender nonconforming student's right to privacy?

To prevent accidental disclosure of a student's transgender status, it is strongly recommended that schools keep records that reflect a transgender student's birth name and assigned sex (e.g., copy of the birth certificate) apart from the student's school records. Schools should consider placing physical documents in a locked file cabinet in the principal's or nurse's office. Alternatively, schools could indicate in the student's records that the necessary identity documents have been reviewed and accepted without retaining the documents themselves. Furthermore, schools should implement similar safeguards to protect against disclosure of information contained in electronic records.

Pursuant to the above protections, schools must consult with a transgender student to determine who can or will be informed of the student's transgender status, if anyone, including the student's family. With rare exceptions, schools are required to respect the limitations that a student places on the disclosure of their transgender status, including not sharing that information with the student's parents. In those very rare circumstances where a school believes there is a specific and compelling "need to know," the school should inform the student that the school intends to disclose the student's transgender status, giving the student the opportunity to make that disclosure her or himself. Additionally, schools must take measures to ensure that any disclosure is made in a way that reduces or eliminates the risk of re-disclosure and protects the transgender student from harassment and discrimination. Those measures could include providing counseling to the student and the student's family to facilitate the family's acceptance and support of the student's transgender status. Schools are not permitted to disclose private student information to other students or the parents of those students.

A transgender student's right to privacy does not restrict a student's right to openly discuss and express their gender identity or to decide when or with whom to share private information. A student does not waive his or her right to privacy by selectively sharing this information with others.

8. What is a school or school district's obligation when a student's stated gender identity is different than the student's gender marker in the school's or district's official records?

A school district is required to maintain a mandatory permanent student record which includes the legal name of the student and the student's gender. If and when a school district receives documentation that such legal name or gender has been changed, the district must update the student's official record accordingly.

If the school district has not received documentation supporting a legal name or gender change, the school should nonetheless update all unofficial school records (e.g. attendance sheets, school IDs, report cards) to reflect the student's name and gender marker that is consistent with the student's gender identity. This is critical in order to avoid unintentionally revealing the student's transgender status to others in violation of the student's privacy rights, as discussed above in section 6.

If a student so chooses, district personnel shall be required to address the student by a name and the pronouns consistent with the student's gender identity, without the necessity of legal documentation or a change to the student's official district record. The student's age is not a factor. For example, children as early as age two are expressing a different gender identity. It is strongly suggested that teachers privately ask transgender or gender nonconforming students at the beginning of the school year how they want to be addressed in class, in correspondence to the home, or at conferences with the student's parents.

In addition to preserving a transgender student's privacy, referring to a transgender student by the student's chosen name and pronouns fosters a safe, supportive and inclusive learning environment. To ensure that transgender students have equal access to the programs and activities provided by the school, all members of the school community must use a transgender student's chosen name and pronouns. Schools should also implement safeguards to reduce the possibility of inadvertent slips or mistakes, particularly among temporary personnel such as substitute teachers.

If a member of the school community intentionally uses a student's incorrect name and pronoun, or persistently refuses to respect a student's chosen name and pronouns, that conduct should be treated as harassment. That type of harassment can create a hostile learning environment, violate the transgender student's privacy rights, and increase that student's risk for harassment by other members of the school community. Examples of this type of harassment include a teacher consistently using the student's incorrect name when displaying the student's work in the classroom, or a transgender student's peers referring to the student by the student's birth name during class, but would not include unintentional or sporadic occurrences. Depending on the circumstances, the school's failure to address known incidents of that type of harassment may violate California's antidiscrimination laws.

9. How does a school or school district determine the appropriate facilities, programs, and activities for transgender students?

A school may maintain separate restroom and locker room facilities for male and female students. However, students shall have access to the restroom and locker room that corresponds to their gender identity asserted at school. As an alternative, a "gender neutral" restroom or private changing area may be used by any student who desires increased privacy, regardless of the underlying reason. The use of such a "gender neutral" restroom or private changing area shall be a matter of choice for a student and no student shall be compelled to use such restroom or changing area.

If there is a reason or request for increased privacy and safety, regardless of the underlying reason, any student may be provided access to a reasonable alternative locker room such as:

- A. Use of a private area in the public area of the locker room facility (i.e., a nearby restroom stall with a door, an area separated by a curtain, or a P.E. instructor's office in the locker room).
- B. A separate changing schedule (either utilizing the locker room before or after the other students).
- C. Use of a nearby private area (i.e., a nearby restroom or a health office restroom).

It should be emphasized that any alternative arrangement should be provided in a way that keeps the student's gender identity confidential.

Schools cannot, however, require a transgender student to use those alternatives. Requiring a transgender student to be singled out by using separate facilities is not only a denial of equal access, it also may violate the student's right to privacy by disclosing the student's transgender status or causing others to question why the student is being treated differently.

Some students (or parents) may feel uncomfortable with a transgender student using the same sex-segregated restroom or locker room. This discomfort is not a reason to deny access to the transgender student. School administrators and counseling staff should work with students and parents to address the discomfort and to foster understanding of gender identity, to create a school culture that respects and values all students.

10. How should a school or district determine the appropriate placement for transgender students related to sports and physical education classes?

Transgender students are entitled to and must be provided the same opportunities as all other students to participate in physical education and sports consistent with their gender identity. Participation in competitive athletic activities and contact sports are to be addressed on a case-by-case basis. For additional guidance, the California Interscholastic Federation issued new bylaws in 2013, which provide a detailed process for gender identity participation in interscholastic sports. (See, Recent Developments section below.)

11. May a school district or school enforce a gender-based dress code?

Nondiscriminatory gender segregated dress codes may be enforced by a school or school district pursuant to district policy. Students shall have the right to dress in accordance with their gender identity, within the constraints of the dress codes adopted by the school. School staff shall not enforce a school's dress code more strictly against transgender and gender nonconforming students than other students.

12. How should school districts and schools address harassment, bullying and abuse of transgender students?

California law requires that schools provide all students with a safe, supportive and inclusive learning environment, free from discrimination, harassment, and bullying. Examples of harassment and abuse commonly experienced by transgender students include, but are not limited to, being teased for failing to conform to sex stereotypes, being deliberately referred to by the name and/or pronouns associated with the student's assigned sex at birth, being deliberately excluded from peer activities, and having personal items stolen or damaged. School district efforts to prevent and address harassment must include strong local policies and procedures for handling complaints of harassment, consistent and effective implementation of those policies, and encouraging members of the school community to report incidents of harassment. Beyond investigating incidents, schools should implement appropriate corrective action to end the harassment and monitor the effectiveness of those actions.

13. Should a school district or school generally review its gender-based policies?

As a general matter, schools should evaluate all gender-based policies, rules, and practices and maintain only those that have a clear and sound pedagogical purpose. Examples of policies and practices that should be reconsidered include: gender-based dress code for graduation or senior portraits and asking students to line up according to gender. Gender-based policies, rules, and practices can have the effect of marginalizing, stigmatizing, and excluding students, whether they are gender nonconforming or not. In some circumstances, these policies, rules, and practices may violate federal and state law. For these reasons, schools should consider alternatives to them.

Whenever students are separated by gender in school activities or are subject to an otherwise lawful gender-specific rule, policy, or practice, students must be permitted to participate in such activities or conform to such rule, policy, or practice consistent with their gender identity.

RECENT DEVELOPMENTS AND RESOURCES

The California School Boards Association's (CSBA) Final Guidance Regarding Transgender Students, Privacy, and Facilities

CSBA has also promulgated a model board policy and administrative regulation that can be adopted by districts:

Board Policy 5145.3 (PDF; Posted 29-Jan-2016)

Administrative Regulation 5145.3 (PDF; Posted 29-Jan-2016)

CSBA also issued a policy brief (PDF) on the issue of how schools can support transgender and gender nonconforming students

Office for Civil Rights Complaint and Resolution Agreement

On July 24, 2013, the U.S. Department of Education's Office for Civil Rights and the U.S. Department of Justice's Civil Rights Division entered into a Resolution Agreement with the Arcadia Unified School District to resolve a complaint alleging violations of Title IX. The case was brought on behalf of a transgender student who was denied access to the boys' restrooms and locker rooms, and required to sleep in a separate facility during an overnight field trip. The agreement requires the school district to treat the student in a manner consistent with his gender identity for all purposes. Moreover, the school district agreed to retain a consultant to revise their policies to prohibit discrimination on the basis of gender identity and implement a district-wide training program for staff and students.

The Resolution Agreement (PDF; Posted 29-Jan-2016) between the Office for Civil Rights and Arcadia Unified School District

California Interscholastic Federation

In February 2013, the California Interscholastic Federation (CIF) issued new bylaws which provide that all students should have the opportunity to participate in CIF activities in a manner that is consistent with their gender identity. CIF Regulation 300 D, Gender Identify Participation, provides:

Participation in interscholastic athletics is a valuable part of the educational experience for all students. All students should have the opportunity to participate in CIF activities in a manner that is consistent with their gender identity, irrespective of the gender listed on a student's records. The student and/or the student's school may seek review of the student's eligibility for participation in interscholastic athletics in a gender that does not match the gender assigned to him or her at birth, should either the student or the school have questions or need guidance in making the determination, by working through the procedure set forth in the "Guidelines for Gender Identity Participation."

NOTE: The student's school may make the initial determination whether a student may participate in interscholastic athletics in a gender that does not match the gender assigned to him or her at birth.

The new California Interscholastic Federation bylaws

Office for Civil Rights, Questions and Answers on Title IX and Sexual Violence, April 29, 2014

In April 2014, the U.S. Department of Education, Office for Civil Rights, issued guidance making clear that federal law prohibits discrimination against students on the basis of transgender status: "Title IX's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and OCR accepts such complaints for investigation (PDF; Posted 29-Jan-2016)."

Office for Civil Rights Dear Colleague Letter, October 26, 2010

In October 2010, the U.S. Department of Education, Office for Civil Rights, issued a Dear Colleague Letter that, among other things, clarified that although Title IX does not prohibit discrimination on the basis of sexual orientation, harassment directed at a student because that student is gay, lesbian, bisexual, or transgender may constitute sexual harassment and sex discrimination prohibited by Title IX.

The U.S. Department of Education, Office for Civil Rights, Dear Colleague Letter, October 26, 2010 (PDF; Posted 29-Jan-2016)

Other Resources

Gay-Straight Alliance Network/Tides Center, Transgender Law Center and National Center for Lesbian Rights. (2004). Beyond the Binary: A Tool Kit for Gender Identity Activism in Schools. San Francisco, CA: GSA Network (PDF; Posted 29-Jan-2016)

Gerald P. Mallon, "Practice with Transgendered Children," in *Social Services with Transgendered Youth* 49, 55-58 (Gerald P. Mallon ed., 1999)

Stephanie Brill & Rachel Pepper, *The Transgender Child*, 61-64 (2008).

Questions: School Health and Safety Office | shso@cde.ca.gov | 916-319-0914

Last Reviewed: Thursday, September 16, 2021

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Trending in Department Information
Contact Us
Student Records & Transcripts
District Transfers
Employment Opportunities
Job Announcements
More Trending Items

Recently Posted in Department Information
Student Achievement Branch (added 18-Nov-2022)
Information for divisions of the California Department of Education's Student Achievement Branch.

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

AURORA REGINO

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Harmeet K. Dhillon (SBN 207873)
DHILLON LAW GROUP INC.
177 Post Street, Suite 700
San Francisco, CA 94108

Joshua W. Dixon
Eric A. Sell
CENTER FOR AMERICAN LIBERTY
1311 South Main Street, Suite 302
Mount Airy, MD 21771

DEFENDANTS

SUPERINTENDENT KELLY STALEY, in her official capacity, CAITLIN DALBY, in her official capacity, REBECCA KONKIN, in her official capacity, TOM LANDO, in his official capacity, EILEEN ROBINSON, in her official capacity, MATT TENNIS, in his official capacity,

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

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- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
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- ☐ 385 Property Damage Product Liability

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- ☐ 441 Voting
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- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
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Habeas Corpus:
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- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
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- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 USC 1983

Brief description of cause:
Defendants infringed Plaintiff's parental rights under the Due Process Clause to the United States Constitution

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE _____ DOCKET NUMBER _____

DATE
1/6/2023

SIGNATURE OF ATTORNEY OF RECORD
/s/ Harmeet K. Dhillon

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.