

Docket No. 23-16031

In the
United States Court of Appeals
For the
Ninth Circuit

AURORA REGINO,

Plaintiff-Appellant,

v.

KELLY STALEY, Superintendent,

Defendant-Appellee,

and

CAITLIN DALBY; REBECCA KONKIN; TOM LANDO;
EILEEN ROBINSON; MATT TENNIS,

Defendants.

*Appeal from a Decision of the United States District Court for Eastern California, Sacramento,
No. 2:23-cv-00032-JAM-DMC Honorable John A. Mendez*

EXCERPTS OF RECORD
VOLUME 1 OF 1

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TABLE OF CONTENTS

Docket Entry	Description	ER Page No.
	VOLUME 1 OF 1	
58	Judgment, Filed July 11, 2023	3
57	Order Granting Defendants' Motion to Dismiss, Filed July 11, 2023	4
	Transcript of Motion to Dismiss, dated June 27, 2023	24
50	Appellee's Motion to Dismiss and Memorandum In Support, Filed April 25, 2023	30
42	First Amended Complaint, filed April 10, 2023	52
	Exhibit A Email, dated January 13, 2023	82
	Exhibit B Chico Unified School District Website Page: Our Schools	85
	Exhibit C Chico Unified School District Website Page: Our District	87
	Exhibit D Chico Unified School District Website Page: Board Information	89
	Exhibit E Chico Unified School District Website Page: Superintendent's Office	91
	Exhibit F Chico Unified School District Nondiscrimination/Harassment Code of Conduct	93
	Exhibit G Frequently Asked Questions	101
	Proof of Service, dated April 10, 2023	103
18-3	Affidavit of Dr. Stephen B. Levine, dated January 4, 2023	105
	Exhibit A Curriculum Vita of Stephen B. Levine, M.D.	228
59	Notice of Appeal, Filed July 20, 2023	253
	Docket Entries	256

**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA**

JUDGMENT IN A CIVIL CASE

AURORA REGINO,

CASE NO: 2:23-CV-00032-JAM-DMC

V.

KELLY STALEY, ET AL.,

Decision by the Court. This action came before the Court. The issues have been tried, heard or decided by the judge as follows:

IT IS ORDERED AND ADJUDGED

**THAT JUDGMENT IS HEREBY ENTERED IN ACCORDANCE WITH THE
COURT'S ORDER FILED ON 7/11/2023**

Keith Holland
Clerk of Court

ENTERED: **July 11, 2023**

by: /s/ L. Reader
Deputy Clerk

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

AURORA REGINO,

Plaintiff,

v.

SUPERINTENDENT KELLY STALEY,
in her official capacity, et
al.,

Defendants.

No. 2:23-cv-00032-JAM-DMC

**ORDER GRANTING DEFENDANT'S
MOTION TO DISMISS**

Chico Unified School District (the "District") Superintendent Kelly Staley ("Defendant") has filed a motion to dismiss Aurora Regino's ("Plaintiff") first amended complaint ("FAC"). See Mot. to Dismiss ("Mot."), ECF No. 50; FAC, ECF No. 42. Plaintiff has brought the following causes of action under 42 U.S.C. § 1983 against Defendant regarding District Regulation AR 5145.3 (the "Regulation"): (1) facial and as-applied substantive due process; (2) facial and as-applied procedural due process; and (3) facial and as-applied First Amendment familial associations. See FAC. Plaintiff alleges that the Regulation results in the District "socially transitioning" students expressing a transgender identity without notifying and obtaining the informed consent of parents, in

1 violation of her constitutional rights. FAC ¶¶ 95-96. Plaintiff
2 opposes the motion to dismiss. See Opp'n, ECF No. 52. Defendant
3 replied. See Reply, ECF No. 54.

4 For the reasons set forth below, the Court GRANTS
5 Defendant's motion.

6 I. FACTUAL ALLEGATIONS AND PROCEDURAL BACKGROUND

7 In her FAC, Plaintiff alleges that District Regulation
8 AR 5145.3 (the "Regulation") (1) permits school personnel to
9 socially transition students expressing a transgender identity by
10 referring to them by their preferred name and pronouns; and
11 (2) prohibits school personnel from informing a student's parents
12 of this change unless the student expressly authorizes them to do
13 so; there is an exception where disclosure is either (1) required
14 by law or (2) the District has compelling evidence that
15 disclosure is necessary to preserve the student's health. FAC
16 ¶ 52. During the 2021-22 school year, Plaintiff's eldest child,
17 A.S., then a student at Sierra View Elementary School, expressed
18 feelings of gender dysphoria to her school counselor, Mandi
19 Robinson, specifically that she identified as a boy. Id. ¶¶ 55-
20 60. A.S. also informed Robertson that she did not want Plaintiff
21 to be informed about her transgender identity on the belief that
22 Plaintiff would be upset. Id. ¶ 64. After a couple of
23 subsequent counseling sessions, Plaintiff alleges that A.S.'s
24 counselor began socially transitioning A.S. by informing her
25 teachers that she was to be called by her new name and referred
26 to by male pronouns. Id. ¶¶ 64-66. School personnel did not
27 disclose these developments to Plaintiff; Plaintiff further
28 alleges that Robinson actively discouraged A.S. from informing

1 Plaintiff and instead advised her to disclose her new identity to
2 other family members before informing Plaintiff. Id. ¶¶ 69-71.
3 Robinson also did not suggest that A.S. discuss her gender
4 dysphoria with a medical professional. Id. ¶ 71.

5 On April 8, 2022, A.S. informed her grandmother of her new
6 gender identity. Id. ¶ 72. A.S.'s grandmother then informed
7 Plaintiff the same day. Id. Plaintiff spent the following
8 months in contact with school district personnel to express her
9 concerns about the Regulation and advocated for the school
10 district to change it. Id. ¶¶ 78-87. Plaintiff alleges that
11 district personnel dismissed her concerns and claimed that state
12 law mandated the Regulation. Id. A.S. currently does not
13 express feelings of gender dysphoria, identifies as a girl again,
14 and is currently in counseling for depression and anxiety. Id.
15 ¶ 94. Plaintiff further alleges that her younger daughter, C.S.,
16 is now exhibiting behaviors that cause Plaintiff to believe that
17 C.S. is likely to express a transgender identity in the future.
18 Id. ¶ 94.

19 On January 6, 2023, Plaintiff filed her complaint against
20 Defendant alleging four causes of action under 42 U.S.C. § 1983:
21 two facial challenges to the Regulation under substantive and
22 procedural due process; and two as-applied challenges to the
23 Policy under substantive and procedural due process. See Compl.,
24 ECF No. 1. Plaintiff subsequently filed a motion for preliminary
25 injunction ("MPI") seeking to enjoin Defendant and all district
26 employees from: (1) socially transitioning current students
27 without obtaining informed consent from the students' parents or
28 guardians; (2) not obtaining informed consent from the parents or

1 guardians of all current students who have previously been
2 socially transitioned or are currently being socially
3 transitioned; (3) socially transitioning Plaintiff's children
4 without her informed consent; and (4) not obtaining Plaintiff's
5 informed consent if her daughters have been socially transitioned
6 in the past or are still being socially transitioned. See MPI,
7 ECF No. 18. The Court denied the MPI. Order, ECF No. 37.
8 Plaintiff next filed her FAC and Defendant filed the instant
9 motion to dismiss the FAC in its entirety. See FAC, Mot.

10 II. EVIDENTIARY ISSUES

11 A. Judicial Notice

12 Defendants request the Court take judicial notice of four
13 exhibits. See Request for Judicial Notice, ECF No. 51. Exhibit
14 A is the District's Administrative Regulation 5145.3; Exhibit B
15 is the definition of "social transition" as provided by the World
16 Professional Association for Transgender Health Standards of Care
17 for the Health of Transgender and Gender Diverse People, Version
18 8 ("WPATH SOC 8"); Exhibit C is the New Hampshire Superior
19 Court's order in Jane Doe v. Manchester School District, Case No.
20 216-2022CV-00117 (N.H. Superior Court, Hillsborough County,
21 Northern District, Sept. 5, 2022); Exhibit D is the California
22 Department of Education's ("CDE") publication: "Frequently Asked
23 Questions: School Success and Opportunity Act (Assembly Bill
24 1266)." Id. at 2. Exhibits A and D constitute government
25 records and are, therefore, proper subjects for judicial notice.
26 Anderson v. Holder, 673 F.3d 1089, 1094 n. 1 (9th Cir. 2012);
27 Daniels-Hall v. National Educ. Ass'n., 629 F.3d 992, 998 (9th
28 Cir. 2010). Exhibit C constitutes a state court proceeding,

1 which is a proper subject for judicial notice. Trigueros v.
2 Adams, 658 F.3d 983, 987 (9th Cir. 2011).

3 Plaintiff opposes judicial notice of Exhibit C, specifically
4 the definition of "transition," arguing that it is too broad and
5 inapplicable to the instant case, which concerns "social
6 transitioning." Opp'n, ECF No. 53 at 2-3. Plaintiff further
7 contends that inclusion of the entire WPATH Guidelines should not
8 be permitted because the exhibit is voluminous and is not relied
9 upon in the FAC. Id. at 2-4. The Court concurs and finds that
10 Exhibit C is not a proper subject for judicial notice. However,
11 the Court takes judicial notice that Exhibit C contains a
12 definition of "social transition."

13 III. OPINION

14 A. Legal Standard

15 In considering a motion to dismiss for failure to state a
16 claim upon which relief can be granted under FRCP 12(b)(6), the
17 Court must accept the allegations in the complaint as true and
18 draw all reasonable inferences in favor of the Plaintiff. Moss
19 v. U.S. Secret Serv., 572 F.3d 962, 969 (9th Cir. 2009) (citing
20 Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009)). The complaint must
21 possess more than "a formulaic recitation of the elements of a
22 cause of action;" it must contain non-conclusory, factual
23 allegations sufficient "to raise a right to relief above the
24 speculative level." Bell Atlantic Corp. v. Twombly, 550 U.S.
25 544, 554 (2007). The Court may dismiss a complaint as a matter
26 of law for "(1) lack of a cognizable legal theory or
27 (2) insufficient facts under a cognizable legal claim."
28 SmileCare Dental Grp. v. Delta Dental Plan of California, Inc.,

88 F.3d 780, 783 (9th Cir. 1996).

B. Analysis

1. Count One: § 1983 Substantive Due Process-Facial Challenge

Defendant argues that Plaintiff's facial challenge to the Regulation under substantive due process must be dismissed on several grounds: (1) Plaintiff has not alleged the deprivation of a federally recognized constitutional right nor conduct that would "shock the conscience" of the Court; (2) Plaintiff cannot establish that there is no set of circumstances in which the Regulation would be valid; and (3) in the absence of a constitutional violation, the Regulation satisfies rational basis review. Mot. at 11-12, 14-17. Defendant contends that the parental right to make decisions regarding the care, custody, and control of one's children does not extend to the circumstances of the instant case. Id. at 11. Defendant refers to Nguon v. Wolf, where a federal district court found that students have a legally protected privacy interest under the California constitution with respect to information about their sexual orientation. 517 F. Supp. 2d 1177, 1196 (C.D. Cal. 2007); id. at 12. Defendant also cites a recent Maryland district court's holding that parents do not have a right to be informed of their child's transgender identity by schools. John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 622 F. Supp. 3d 118, 130 (D. Md. 2022). Defendant claims that there is no federal right to notice and consent to treatment for parents when their minor children voluntarily seek medical and psychological care, and that Plaintiff cannot establish that the conduct at issue in the instant case "shocks

1 the conscience;" the Regulation simply requires that District
2 staff respect the gender identity and privacy wishes of students.
3 Mot. at 14-16. Furthermore, Defendant argues that there are
4 circumstances where disclosure can lead to harm to students, so
5 the District has a legitimate state interest in protecting
6 students' privacy and creating a "zone of protection" from
7 potential domestic violence. Id. at 16-17.

8 Plaintiff responds that her substantive parental rights
9 extend to the circumstances of the instant case and that she is
10 not required to provide a careful description of her right to
11 support her substantive causes of action. Opp'n, ECF No. 52 at
12 3. Nevertheless, Plaintiff claims that the Regulation violates
13 her substantive due process rights to (1) make medical decisions
14 for her children and (2) make important decisions in the lives of
15 her children that go to the heart of parental decision making.
16 Id. at 3-4. Plaintiff argues that social transitioning is a
17 significant form of psychological treatment, referring to the
18 Ninth Circuit's opinion in Edmo v. Corizon, Inc., where the Court
19 acknowledged the WPATH Standards of Care's identification of
20 social transitioning as a form of treatment for those suffering
21 from gender dysphoria. 935 F.3d 757, 770 (9th Cir. 2019); Opp'n
22 at 4. Plaintiff claims that social transitioning can have grave
23 consequences for children, including a higher likelihood that
24 children will seek other gender-affirming care and a lower
25 likelihood that a child will return to their original gender
26 identity. Id. Plaintiff argues that children are unable to
27 provide informed consent to such serious psychological treatment,
28 so parental consent is required, comparing the instant case to

1 Mann v. Cnty. of San Diego, where the Ninth Circuit held that
2 parental consent was required for physically invasive medical
3 examinations of minors. 907 F.3d 1154, 1162 (9th Cir. 2018);
4 Opp'n at 4. Plaintiff then likens the instant case to other
5 parental decisions such as (1) child visitation; (2) whether to
6 send a child to private school; (3) the academic subjects that
7 children may be taught; and (4) curfew. Id. at 4-5. Plaintiff
8 also refers to a Kansas district court holding in Ricard v. USD
9 475 Geary Cnty., KS Sch. Bd., which stated that parents must be
10 included in any decision regarding what names and pronouns their
11 children are referred to in school to support her claim that the
12 Regulation will result in children suffering from gender
13 dysphoria alone without parental guidance. No. 522CV04015HLTGE, B,
14 2022 WL 1471372, at *8 (D. Kan. May 9, 2022); Opp'n at 5.

15 Having carefully and thoroughly considered the arguments
16 raised by the parties in their briefs and the oral argument on
17 this motion held on June 27, 2023, the Court finds that Plaintiff
18 has failed to allege sufficient facts to support her facial
19 substantive due process claim. To establish a substantive due
20 process claim under § 1983, a plaintiff must allege that (1) a
21 federal constitutional right was violated and (2) the alleged
22 violation was committed by a person acting under the color of
23 state law such that it shocks the conscience. Long v. Cnty. of
24 Los Angeles, 442 F.3d 1178, 1185 (9th Cir. 2006), Brittain v.
25 Hansen, 451 F.3d 982, 991 (9th Cir. 2006). This Court has held
26 that the threshold requirement for such substantive or procedural
27 due process claims is "plaintiff's showing of a liberty or
28 property interest protected by the Constitution." Culinary

1 Studios, Inc. v. Newsom, 517 F. Supp. 3d 1042, 1067 (E.D. Cal.
2 2021) (citing Wedges/Ledges of California, Inc. v. City of
3 Phoenix, Ariz., 24 F.3d 56, 62 (9th Cir. 1994)). The Supreme
4 Court requires a "careful description of the asserted liberty
5 interest" that has been violated. Washington v. Glucksberg, 521
6 U.S. 702, 720 (1997). The Court has also cautioned against the
7 expansion of substantive due process rights, "lest the liberty
8 protected by the Due Process Clause be subtly transformed into
9 the policy preferences of" the courts. Id. Although the "law
10 does not require a case directly on point for a right to be
11 clearly established, existing precedent must have placed the
12 statutory or constitutional question beyond debate." David v.
13 Kaulukukui, 38 F.4th 792, 800 (9th Cir. 2022).

14 Despite Plaintiff's claims to the contrary, she is
15 advocating for an expansion of her parental substantive due
16 process rights that is not supported by precedent. Plaintiff has
17 failed to provide any controlling authority that would permit
18 this Court to find that the scope of her substantive parental
19 rights covers the instant case's circumstances. None of the
20 cases cited by Plaintiff opine on whether the state has an
21 affirmative duty to inform parents of their child's transgender
22 identity nor whether the state must obtain parental consent
23 before referring to a transgender child by their preferred name
24 and pronouns. Even Plaintiff's reliance on Ricard is misguided
25 as its holding was made in the context of a religious free
26 exercise claim where the plaintiff teacher argued that
27 withholding a student's transgender status from their parents
28 violated plaintiff's religious beliefs; substantive parental

1 rights were not at issue before the Ricard court. Also, while
2 Plaintiff alleges that the Regulation permits social
3 transitioning at school and this constitutes medical treatment,
4 this allegation is conclusory and, thus, insufficient to raise
5 Plaintiff's right to relief under substantive due process above
6 the speculative level.

7 The Court further notes that the sections of the Regulation
8 at issue in the instant case are not proactive, but reactive;
9 District staff are not directed to force students to adopt
10 transgender identities or keep their identities secret from their
11 parents. Instead, District staff are directed to affirm a
12 student's expressed identity and pronouns and disclose that
13 information only to those the student wishes, with an exception
14 for the student's health. On the Regulation's face, it is
15 undisputable that the decision to openly express a transgender
16 identity through the use of a different name and pronouns is made
17 by the student, not the District; and Plaintiff has failed to
18 demonstrate that the Court has the authority under substantive
19 due process to direct the District's response to such a decision
20 on the grounds that her parental rights apply. Federal courts
21 are "courts of limited jurisdiction that have not been vested
22 with open-ended lawmaking powers," so in the absence of an
23 established constitutional right, the legislature is best suited
24 to address Plaintiff's concerns.¹ Nw. Airlines, Inc. v. Transp.

25
26 ¹ The California legislature is currently considering a bill that
27 would require school employees to notify a student's parent or
28 guardian when the school becomes aware that the student is
expressing a transgender identity. See Cal. Assemb. B. 1314
(2023-2024 Reg. Sess.).

1 Workers Union of Am., AFL-CIO, 451 U.S. 77, 95 (1981).

2 As Defendant notes, Plaintiff's FAC and opposition to this
3 motion to dismiss is filled with policy arguments challenging the
4 wisdom of the Regulation. While reasonable minds may certainly
5 differ as to whether Plaintiff's policy preferences are
6 advisable, this Court is not the venue for this political debate.
7 Reply, ECF No. 54 at 2. The issue before this Court is not
8 whether it is a good idea for school districts to notify parents
9 of a minor's gender identity and receive consent before using
10 alternative names and pronouns, but whether the United States
11 Constitution mandates such parental authority. This Court holds
12 that it does not.

13 In the absence of the establishment of a federal
14 constitutional right, the Regulation is subject to rational basis
15 review, so the Regulation need only bear some rational
16 relationship to a legitimate state interest. Witt v. Dep't of
17 Air Force, 527 F.3d 806, 817 (9th Cir. 2008). The Court finds
18 that the Defendant has demonstrated a legitimate state interest
19 in creating a zone of protection for transgender students and
20 those questioning their gender identity from adverse hostile
21 reactions, including, but not limited to, domestic abuse and
22 bullying; this is in line with the Regulation's general purpose
23 to combat discrimination and harassment against students.
24 Plaintiff's facial substantive due process challenge thus fails
25 as a matter of law and is dismissed.

26 2. Count Two: § 1983 Substantive Due Process-As-
27 Applied Challenge

28 Defendant argues that Plaintiff's as-applied substantive due

1 process claim must be dismissed because Plaintiff has failed to
2 satisfy the underlying constitutional standard, namely that
3 (1) Plaintiff had a federal constitutional right that was
4 violated; and (2) the alleged violation was committed by a person
5 acting under the color of state law such that it shocks the
6 conscience. Mot. at 17. Defendant also argues that instruction
7 regarding sexual identity does not infringe upon parental rights
8 because it falls under a school's curriculum. Id. Defendant
9 further notes that A.S.'s feelings of gender dysphoria, desire to
10 use a different name and pronouns, and decision to not disclose
11 her transgender identity to Plaintiff were prompted by A.S., not
12 school personnel. Id. at 17-19. With respect to disclosure to
13 Plaintiff, Defendant contends that Robertson's suggestion that
14 A.S. disclose her gender identity to other family members first
15 was in line with the Regulation's guidelines and that Robertson
16 did not expressly forbid A.S. from disclosing this information to
17 Plaintiff. Id. at 19.

18 Plaintiff does not directly contest Defendant's arguments in
19 her opposition brief and the Court finds that Plaintiff has
20 failed to allege sufficient facts to support her as-applied
21 challenge. As Defendant notes, the underlying constitutional
22 standard for an as-applied challenge is the same as a facial
23 challenge. Legal Aid Servs. of Or. v. Legal Servs. Corp., 608
24 F.3d 1084, 1096 (9th Cir. 2010). Thus, Plaintiff must establish
25 the requisite elements for a substantive due process claim,
26 namely that: (1) a federal constitutional right was violated and
27 (2) the alleged violation was committed by a person acting under
28 the color of state law such that it shocks the conscience. Long,

1 442 F.3d at 1185, Brittain, 451 F.3d at 991. Plaintiff has
2 failed to establish these elements. Consistent with the Court's
3 ruling in favor of Defendant on count one, the Court finds that
4 Plaintiff's as-applied substantive due process challenge fails as
5 a matter of law and is dismissed.

6 3. Count Three: § 1983 Procedural Due Process-Facial
7 Challenge

8 Defendant argues that Plaintiff's facial procedural due
9 process claim must be dismissed because Plaintiff has failed to
10 establish that she has been deprived of a protected interest in
11 property or liberty. Mot. at 20. Defendant further contends
12 that, even if there was a constitutional violation, Plaintiff has
13 failed to put forth any allegations to suggest that the District
14 enacted the Regulation in a manner prohibited by law. Id. at 20-
15 21.

16 Plaintiff responds that (1) the Regulation violates her
17 fundamental parental rights and (2) in the alternative, her
18 parental rights are closely related enough to fundamental rights
19 that they should trigger procedural due process protections.
20 Opp'n at 13-14. With respect to process, Plaintiff claims that
21 the Regulation's adjudicatory framework is procedurally deficient
22 because it does not allow for a thorough investigation into the
23 relevant facts of one's case, notice, and an opportunity to be
24 heard. Opp'n at 14, FAC ¶ 120.

25 To establish a procedural due process violation under
26 § 1983, a plaintiff must allege: "(1) a deprivation of a
27 constitutionally protected liberty or property interest and (2) a
28 denial of adequate procedural protections." Culinary Studios,

1 Inc., 517 F. Supp. 3d at 1067 (citing Tutor-Saliba Corp., 452
2 F.3d at 1061). This Court has held that the threshold
3 requirement for such a claim is "plaintiff's showing of a liberty
4 or property interest protected by the Constitution." Id. (citing
5 Wedges/Ledges of California, Inc., 24 F.3d at 62). Although the
6 "law does not require a case directly on point for a right to be
7 clearly established, existing precedent must have placed the
8 statutory or constitutional question beyond debate." Kaulukukui,
9 38 F.4th at 800. Consistent with the Court's rulings in favor of
10 Defendant on counts one and two, the Court finds that Plaintiff
11 has failed to allege sufficient facts to establish that her
12 fundamental parental rights extend to the circumstances of the
13 instant case such that she was entitled to procedural due process
14 protections; thus, Plaintiff has not sufficiently alleged that
15 she has been deprived of a constitutionally protected liberty or
16 property interest and her claim must be dismissed.

17 4. Count Four: § 1983 Procedural Due Process-As-
18 Applied Challenge

19 Given the Court's ruling on Plaintiff's facial challenge,
20 the Court finds that Plaintiff has failed to allege facts
21 sufficient to support her as-applied procedural due process
22 challenge. The underlying constitutional standard for an as-
23 applied challenge is the same as a facial challenge. Legal Aid
24 Servs. of Or., 608 F.3d at 1096 (9th Cir. 2010). Because
25 Plaintiff has failed to allege sufficient facts to establish that
26 she was deprived of a constitutionally protected liberty or
27 property interest in the instant case, her claim must be
28 dismissed.

1 5. Count Five: § 1983 First Amendment-Facial
2 Challenge

3 Defendant seeks dismissal of Plaintiff's facial challenge
4 alleging a violation of her intimate family relationship with her
5 daughter because the right has not been recognized in the context
6 of the instant case. Mot. at 21-22. Defendant argues that the
7 parent-child intimate human relationship has only been recognized
8 in two instances: (1) the right of a parent and child to
9 physically live or congregate together; and (2) where the parent
10 or child suffers retaliation from the state because of the
11 other's conduct. Hameetman v. City of Chicago, 776 F.2d 636 (7th
12 Cir. 1985), Agostino v. Simpson, 2012 U.S. Dist. LEXIS 207375,
13 *26-27 (S.D.N.Y. Mar. 29, 2012); Mot. at 21. Defendant claims
14 that the FAC does not allege that the District either physically
15 separated Plaintiff from A.S. or took any actions that could
16 constitute retaliation against Plaintiff or A.S. for their
17 individual conduct; the District simply abided by A.S.'s request
18 to keep her gender identity a secret from Plaintiff in accordance
19 with the Regulation. Id. at 22. Thus, Defendant contends that
20 there was no constitutional violation. Id.

21 Plaintiff responds that the Regulation infringes on her
22 right to family integrity and association, which prohibits
23 unwarranted state interference into family relationships. Opp'n
24 at 5. Plaintiff claims that Western parental relationships are
25 deeply shaped by whether a child identifies as a boy or girl; the
26 Regulation's alleged facilitation of social transitioning without
27 parental consent fundamentally alters the "emotional bonds" of
28 that relationship. Id. at 5-6; Ovando v. City of Los Angeles, 92

1 F. Supp. 2d 1011, 1021 (C.D. Cal. 2000); Doe v. Dickenson, 615 F.
2 Supp. 2d 1002, 1014 (D. Ariz. 2009). Plaintiff claims that the
3 Regulation drives a wedge into the parent-child relationship and
4 denies Plaintiff the "opportunity to counter influences" on her
5 children with which she disagrees. Arnold v. Bd. of Educ. of
6 Escambia Cnty., 880 F.2d 305, 313 (11th Cir. 1989). Plaintiff
7 argues that as a matter of constitutional law she has the right
8 to decide whether the District socially transitions her children,
9 or, in the alternative, she has the right to be provided notice
10 before social transitioning occurs. The Court disagrees.

11 Plaintiff has failed to allege facts sufficient to support
12 her facial First Amendment challenge. This Court has held that a
13 familial association claim can be brought under either the First
14 or the Fourteenth Amendment and that the standard of proof is the
15 same. Kaur v. City of Lodi, 263 F. Supp. 3d 947, 973 (E.D. Cal.
16 2017). To establish a familial association claim, Plaintiff must
17 show that (1) her liberty interest in having her relationship
18 with A.S. be free from unwarranted state interference was
19 violated; and (2) that the violation was committed through
20 official conduct that "shocks the conscience." Est. of Osuna v.
21 Cnty. of Stanislaus, 392 F. Supp. 3d 1162, 1176 (E.D. Cal. 2019).
22 The Ninth Circuit has also held that recovery for a violation of
23 the right to familial association is generally contingent on the
24 existence of an underlying constitutional violation. Schwarz v.
25 Lassen Cnty. ex rel. Lassen Cnty. Jail, 628 F. App'x 527, 528
26 (9th Cir. 2016). However, Plaintiff has again failed to allege a
27 cognizable constitutional violation. Although the "law does not
28 require a case directly on point for a right to be clearly

1 established, existing precedent must have placed the statutory or
2 constitutional question beyond debate.” Kaulukukui, 38 F.4th at
3 800. Plaintiff has cited to no controlling authority that
4 suggests that a policy that forbids disclosure of a student’s
5 gender identity absent their consent constitutes unwarranted
6 interference in the parent-child relationship. The cases cited
7 by Plaintiff to support her claim bear no resemblance to the
8 instant case. The Regulation does not involve: (1) wrongful
9 imprisonment of a parent, Ovando, 92 F. Supp. 2d at 1019; (2) the
10 molestation of a child by a school resource officer, Dickenson,
11 616 F. Supp. 2d at 1013-14; (3) reputational damage to a parent
12 labelled as a child abuser, Bohn v. Dakota Cnty., 772 F.2d 1433,
13 1436 n.4 (8th Cir. 1985); (4) law enforcement officers giving a
14 family false and defamatory information about a parent, Patel v.
15 Searles, 305 F.3d 130, 136-37 (2d Cir. 2002); (5) school
16 officials coercing students into receiving abortions and not
17 informing their parents, Arnold, 880 F.2d at 312-14; or
18 (6) school officials compelling student athletes to take
19 pregnancy tests, Gruenke v. Seip, 225 F.3d 290, 304-07 (3d Cir.
20 2000).

21 The Regulation only governs the conduct of District staff
22 with respect to how students wish to be addressed. Nothing in
23 the Regulation prohibits or discourages students and their
24 parents from associating with each other. To the contrary, in
25 the context of the instant case, the Regulation refrains from
26 interfering with the established parent-child relationship by
27 allowing students to disclose their gender identity to their
28 parents on their own terms. Consistent with the Court’s rulings

1 in favor of Defendant on counts one through four, the Court finds
2 that Plaintiff has failed to establish that her right to familial
3 association free from unwarranted state interference extends to
4 the circumstances of the instant case or that Plaintiff has
5 suffered an underlying constitutional violation. In the absence
6 of the non-conclusory, factual allegations necessary to sustain
7 this claim, Plaintiff's claim must be dismissed.

8 6. Count Six: § 1983 First Amendment-As-Applied
9 Challenge

10 Given the Court's ruling on Plaintiff's facial challenge,
11 the Court finds that Plaintiff has failed to allege facts
12 sufficient to support her as-applied familial association
13 challenge. The underlying constitutional standard for an as-
14 applied challenge is the same as a facial challenge. Legal Aid
15 Servs. of Or., 608 F.3d at 1096 (9th Cir. 2010). Because
16 Plaintiff has failed to establish that she suffered a
17 constitutional violation in the instant case, her as applied
18 claim must be dismissed. The Court further notes Plaintiff's
19 concession that her alleged constitutional violation occurred
20 upon A.S.'s initiative, not the District's. Specifically, (1) the
21 District's decision to not disclose A.S.'s gender identity to
22 Plaintiff was at the request of A.S. and (2) A.S. affirmatively
23 provided a name and pronouns that she preferred to be referenced
24 by at school. FAC ¶¶ 64.

25 ///

26 ///

27 ///

28 ///

IV. ORDER

For the reasons set forth above, the Court GRANTS Defendant's motion to dismiss. In determining whether to grant leave to amend, courts consider several factors: (1) undue delay, (2) bad faith or dilatory motive; (3) repeated failure to cure deficiencies by amendments previously permitted; (4) prejudice to the opposing party; and (5) futility of amendment. Foman v. Davis, 371 U.S. 178, 182 (1962); United States v. Corinthian Colleges, 655 F.3d 984, 995 (9th Cir. 2011). Futility of amendment can, by itself, justify denial of leave to amend. Bonin v. Calderon, 59 F.3d 815, 845 (9th Cir. 1995). To the extent that the pleadings can be cured by the allegation of additional facts, a plaintiff should be afforded leave to amend. Samano v. LVNV Funding, LLC, No. 1:21-CV-01692-SKO, 2022 WL 2318161, at *2 (E.D. Cal. June 28, 2022) (citing Cook, Perkiss and Liehe, Inc. v. N. Cal. Collection Serv. Inc., 911 F.2d 242, 247 (9th Cir. 1990)). Dismissal of a complaint without leave to amend is proper only if it is absolutely clear that the deficiencies of the complaint could not be cured by amendment, such that the underlying facts cannot create a proper subject of relief. Id. at *4, Breier v. N. Cal. Bowling Proprietors' Ass'n, 316 F.2d 787, 790 (9th Cir. 1963).

In the instant case the Court finds that further amendment would be futile. Clearly, there are no material facts that are disputed or could be added that would allow Plaintiff to proceed on any of her six claims in the FAC. Indeed, the parties conceded at oral argument on this motion that this case presents purely legal issues that can be resolved at this stage of the

proceedings. Accordingly, all of Plaintiff's claims are
DISMISSED WITH PREJUDICE.

IT IS SO ORDERED.

Dated: July 10, 2023


JOHN A. MENDEZ
SENIOR UNITED STATES DISTRICT JUDGE

- - o0o - -

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE JOHN A. MENDEZ
SENIOR UNITED STATES DISTRICT JUDGE

1 SACRAMENTO, CALIFORNIA, TUESDAY, JUNE 27, 2023

2 --o0o--

3 (In open court.)

4 THE CLERK: Please remain seated and come to order.
5 Court is back in session.

6 Calling civil case number 2:23-cv-32 Regino versus
7 Staley.

8 THE COURT: Good afternoon. Counsel, state your
9 appearances, please.

10 MR. DIXON: Josh Dixon, Center for American Liberty on
11 behalf of Plaintiff Aurora Regino, who is also here this
12 morning or this afternoon.

13 THE COURT: Good afternoon.

14 MS. REGINO: Good afternoon.

15 MR. DUUS: Brian Duus of Leon, Alberts & Duus on
16 behalf of the Superintendent Kelly Staley of the Chico Unified
17 School District.

18 THE COURT: All right. Good afternoon.

19 Keep the mic in front of you, make sure we can hear
20 you, but you can remain seated.

21 Before the Court this afternoon is a motion to dismiss
22 by the defendant. The Court has reviewed the briefs and has a
23 few questions for the attorneys.

24 First question -- actually, first comment. There is a
25 request for judicial notice. There's no objection to exhibits

1 We'll come back to that. Okay, that explains it to me.

2 The next question I have for you is this is a motion
3 to dismiss, so we are at a really early stage of the
4 proceedings, but are there any issues of material fact in this
5 case? It seems to me to be almost a purely legal case that the
6 parties almost could try the case on the stipulated set of
7 facts.

8 I'm wondering, because two questions always come up in
9 motions to dismiss: Is there something else you think you need
10 to get from the defendants in discovery which you haven't had
11 an opportunity to do, I assume, and second, if I did grant the
12 motion to dismiss, should I grant leave to amend? I'm going
13 save that for the last part.

14 Just broadly, it's your case, are there facts here
15 that need further development?

16 MR. DIXON: I think, broadly speaking, and Your Honor,
17 respectfully, if I may say this without committing, because
18 this is not something I've fully vetted in my own mind, but I
19 don't believe we would need extensive discovery in any event,
20 maybe none. I do think -- I agree with Your Honor, this could
21 be a case that could potentially be tried on stipulated facts
22 depending upon what the District was willing to stipulate to.

23 For example, we allege in our complaint, as Your Honor
24 is aware, that social transition constitutes psychological
25 treatment. I don't know if a District intends to dispute that

1 fact. They did not for purposes of this proceeding. That may
2 be a potential area that would be disputed, but if not, then
3 yes, I do think it's potential that we could resolve this case
4 on a stipulated set of facts.

5 THE COURT: I can't convert a motion to dismiss to a
6 motion for summary judgment without prior notice, and I don't
7 intend to do that, but reading the briefs -- the second set of
8 briefs I've read. I'm pretty familiar with this case now, I
9 couldn't really see this being the type of case where there
10 needs to be a lot of development of the facts, that there's a
11 lot of disagreement.

12 Mr. Duus, do you disagree? I know Mr. Dixon argued
13 you don't, but I'm under the impression you disagree with their
14 argument that social transitioning is equivalent of
15 psychological treatment, medical treatment.

16 MR. DUUS: I'm not a doctor, Your Honor, but I do
17 disagree with that because I think "social transitioning" is a
18 broad term and it doesn't always constitute medical treatment.

19 THE COURT: Okay.

20 MR. DUUS: But I would add that I don't think that is
21 necessary for the disposition of this motion.

22 THE COURT: Your argument is even if it did constitute
23 medical treatment, that still the policy withstands a
24 constitutional challenge.

25 MR. DUUS: Correct, Your Honor.

1 precisely an act for this Court to stop. If the school, for
2 example, had a policy under which they would tell students that
3 everyday before school if you want to come get an Adderall just
4 to calm you down, we're going to allow that. We're not going
5 to require it, we're going to allow the students to go get it,
6 but sorry, we're not going to tell your parents about that
7 either. I think that would be plainly the provision of medical
8 treatment to the child, the child's choice, the school is not
9 requiring the child to make that choice, but they're conducting
10 medical treatment on children in violation of the parent's
11 constitutional rights to direct and control that.

12 THE COURT: That's not this case, though. It's not
13 even closely analogous to this case.

14 MR. DIXON: But based on our allegation that social
15 transitioning constitutes medical treatment, which again at
16 this stage in the litigation, the Court must accept that is
17 perfectly analogous to what is going on.

18 THE COURT: I only have to accept the fact if I don't
19 think it's a conclusory allegation. I mean, that's based on
20 your expert's testimony.

21 MR. DIXON: You are correct in that, Your Honor, you
22 don't have to accept conclusory allegations, but this is not
23 alleging that a dog is a cat. In *Edmo*, the Ninth Circuit says
24 social transitioning constitutes psychological treatment. We
25 cited three other cases that say the same thing. The *Monroe*

1 case held in the prison context. It would be improper at this
2 stage to discount that allegation; it's not a conclusory
3 allegation.

4 This is not Mr. Iqbal alleging that John Ashcroft was
5 involved in some massive conspiracy to deprive him of his
6 rights. This is well within the range of reason particularly
7 considering the case law that has adopted that proposition.

8 THE COURT: *Edmo* relied on the same definition as the
9 Exhibit B, though, right?

10 MR. DIXON: *Edmo* --

11 THE COURT: The Court acknowledged the WPATH standards
12 of care identification of social transitioning is a form of
13 treatment for those suffering from gender dysphoria, but it
14 relied on, again, the Exhibit B, not your expert's view, but
15 the requests for judicial notice Exhibit B definition, right?

16 MR. DIXON: No, it didn't, Your Honor. To be clear,
17 the *Edmo* did rely on the WPATH guidelines generally, but not
18 the definition -- all the defendant sought to introduce was the
19 definition of "social transitioning."

20 THE COURT: Right.

21 MR. DIXON: That's what we objected to. *Edmo* does
22 rely on the WPATH for purposes of including whether it's
23 medical treatment, psychological treatment.

24 THE COURT: But, again, your only evidence that using
25 someone's preferred name and pronouns, your only support that

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Attorneys for Defendant
SUPERINTENDENT KELLY STALEY,
in her official capacity

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

AURORA REGINO,

Plaintiff,

vs.

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.: 2:23-cv-00032-JAM-DMC

**DEFENDANT SUPERINTENDENT
KELLY STALEY'S NOTICE OF MOTION
AND MOTION TO DISMISS FIRST
AMENDED COMPLAINT**

(Fed. R. Civ. Proc. 12)

Date: June 27, 2023

Time: 1:30 p.m.

Crtrm.: 6

Judge: Hon. John A. Mendez

Complaint Filed: January 6, 2023

Trial Date: Not Yet Set

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that on June 27, 2023 at 1:30 p.m., or as soon thereafter as the matter may be heard in Courtroom 6 of the above-entitled court, located at 501 I Street, Sacramento, California 95814, Defendant KELLY STALEY (“Superintendent Staley”) will and hereby does move this Court to dismiss the following claims raised in the operative First Amended Complaint filed by Plaintiff AURORA REGINO in the above-captioned matter (“FAC”):

1. First Cause of Action pursuant to Federal Rule of Civil Procedure 12(b)(6) (“Rule 12(b)(6)”), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States;
2. First Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an abuse of power which shocks the conscience;
3. Second Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States;
4. Second Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an abuse of power which shocks the conscience;
5. Third Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States;
6. Third Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an abuse of power which shocks the conscience;
7. Third Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege facts establishing an entitlement to individual notice and hearing;
8. Fourth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States;
9. Fourth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an

- abuse of power which shocks the conscience;
10. Fourth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege facts establishing an entitlement to individual notice and hearing;
11. Fifth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States;
12. Fifth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an abuse of power which shocks the conscience;
13. Sixth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege the deprivation of a life, liberty or property right secured by the Constitution or laws of the United States; and
14. Sixth Cause of Action pursuant to Rule 12(b)(6), as the FAC does not allege an abuse of power which shocks the conscience.

This motion is based on the instant Notice of Motion and Motion, the Memorandum of Points and Authorities set forth below, the contemporaneously-filed request for judicial notice, all pleadings in this action, as well as any evidence and arguments that may be offered in the forthcoming reply briefing and hearing on the motion. This motion is made following the conference of counsel pursuant to the Court's standing order which took place on April 18, 2023.

LEONE ALBERTS & DUUS

Dated: April 25, 2023

/s/ Jimmie E. Johnson
BRIAN A. DUUS, ESQ.
JIMMIE E. JOHNSON, ESQ.
Attorneys for Defendants

TABLE OF CONTENTS

	<u>Page</u> <u>No.</u>
PERTINENT BACKGROUND	9
ARGUMENT	11
I. THE FAC FAILS TO STATE FACTS CONSTITUTING A FACIAL VIOLATION OF PLAINTIFF’S SUBSTANTIVE DUE PROCESS RIGHTS	11
A. PLAINTIFF FAILS TO ALLEGE THE DEPRIVATION OF A RIGHT SECURED BY FEDERAL LAW.	11
i. PARENTS DO NOT HAVE A RIGHT TO IMPOSE THEIR GENDER IDENTITY PREFERENCES	11
ii. PARENTS DO NOT HAVE A RIGHT TO IMPOSE THEIR CURRICULUM PREFERENCES	13
iii. PARENTS DO NOT HAVE A RIGHT TO NOTICE AND CONSENT TO TREATMENT	14
B. PLAINTIFF FAILS TO ALLEGE DISTRICT CONDUCT THAT “SHOCKS THE CONSCIENCE”	15
C. PLAINTIFF CANNOT SHOW AR 5145.3 WOULD BE INVALID IN EVERY CIRCUMSTANCE.....	16
D. AR 5145.3 SATISFIES RATIONAL BASIS REVIEW	16
II. THE FAC FAILS TO STATE FACTS CONSTITUTING AN AS-APPLIED VIOLATION OF PLAINTIFF’S SUBSTANTIVE DUE PROCESS RIGHTS	17
III. THE FAC FAILS TO STATE FACTS CONSTITUTING A VIOLATION OF PLAINTIFF’S PROCEDURAL DUE PROCESS RIGHTS	20
IV. THE FAC FAILS TO STATE FACTS CONSTITUTING A FACIAL VIOLATION OF PLAINTIFF’S INTIMATE HUMAN RELATIONSHIP RIGHTS.....	21
V. THE FAC FAILS TO STATE FACTS CONSTITUTING AN AS-APPLIED VIOLATION OF PLAINTIFF’S INTIMATE HUMAN RELATIONSHIP RIGHTS.....	22

Table of Authorities

<i>Agostino v. Simpson</i> , 2012 U.S. Dist. LEXIS 207375 (S.D.N.Y. Mar. 29, 2012)	21
<i>Am. Mfrs. Mut. Ins. Co. v. Sullivan</i> , 526 U.S. 40 (1999)	20
<i>Bellotti v. Baird</i> , 443 U.S. 622 (1979)	14, 15, 16
<i>Bi-Metallic Inv. Co. v. State Bd. of Equalization</i> , 239 U.S. 441 (1915)	20
<i>Bovee v. Broom</i> , 2012 U.S. Dist. LEXIS 15314 (S.D. Ill. Feb. 7, 2012)	21
<i>Brittain v. Hansen</i> , 451 F.3d 982 (9th Cir. 2006)	11, 17, 22
<i>C.N. v. Wolf</i> , 410 F.Supp.2d 894 (C.D. Cal. 2005)	12
<i>Cnty. of Sacramento v. Lewis</i> , 523 U.S. 833 (1998)	15
<i>Culinary Studios, Inc. v. Newsom</i> , 517 F.Supp.3d 1042 (E.D. Cal. 2021)	21
<i>Doe v. Irwin</i> , 615 F.2d 1162 (6th Cir. 1980)	12-13, 14
<i>Fields v. Palmdale Sch. Dist.</i> , 427 F.3d 1197 (9th Cir. 2005)	11, 12, 13, 17
<i>IDK, Inc. v. Cnty. of Clark</i> , 836 F.2d 1185 (9th Cir. 1988)	21
<i>Halverson v. Skagit Cnty</i> , 42 F.3d 1257 (9th Cir. 1994)	20
<i>Hameetman v. City of Chicago</i> , 776 F.2d 636 (7th Cir. 1985)	21
<i>Hernandez v. Cnty of Alameda</i> , 2023 U.S. Dist. LEXIS 11260 (N.D. Cal. Jan. 23, 2023)	21
<i>Hoye v. City of Oakland</i> , 653 F.3d 835 (9th Cir. 2011)	17

<i>In re Gault</i>	
387 U.S. 1 (1967)	14
<i>John & Jane Parents I v. Montgomery Cnty. Bd. of Educ.</i>	
2022 U.S. Dist. LEXIS 149021 (D. Md. Aug. 18, 2022)	12, 16, 17
<i>Legal Aid Servs. of Or. v. Legal Servs. Corp.,</i>	
608 F.3d 1084 (9th Cir. 2010)	17
<i>Mueller v. Auken,</i>	
700 F.3d 1180 (9th Cir. 2012)	16
<i>Nguon v. Wolf,</i>	
517 F.Supp.2d 1177 (C.D. Cal. 2007)	12
<i>Nelson v. NASA,</i>	
568 F.3d 1028 (9th Cir. 2009)	12
<i>Nunez by Nunez v. City of San Diego,</i>	
114 F.3d 935 (9th Cir. 1997)	14, 15
<i>Parents for Privacy v. Barr,</i>	
949 F.3d 1210 (9th Cir. 2020)	13, 17
<i>Planned Parenthood of Idaho, Inc. v. Wasden,</i>	
376 F. Supp. 2d 1012 (D. Idaho 2005)	14
<i>Planned Parenthood v. Miller,</i>	
63 F.3d 1452 (8th Cir. 1995)	14
<i>Sterling v. Borough of Minersville,</i>	
232 F.3d 190 (3d Cir. 2000)	12
<i>Sylvia Landfield Trust v. City of Los Angeles,</i>	
729 F.3d 1189 (9th Cir. 2013)	15
<i>Thomas v. Evansville-Vanderburgh Sch. Corp.</i>	
258 Fed.Appx. 50 (7th Cir. 2007)	13, 14
<i>United States v. Salerno,</i>	
481 U.S. 739 (1987)	11, 16
<i>Wallis v. Spencer,</i>	
202 F.3d 1126 (9th Cir. 2000)	21
<i>Washington v. Glucksberg,</i>	
521 U.S. 702 (1997)	17
<i>Whalen v. Roe,</i>	
429 U.S. 589 (1977)	12

Witt v. Dep’t. of the Air Force,
527 F.3d 806 (9th Cir. 2008) 17

Roberts v. U.S. Jaycees
468 U.S. 609 (1984) 21

Statutes

42 U.S.C. § 1983 11, 15, 20, 21

California Education Code § 33308.5(a) 16

Other

District Administrative Regulation 5145.3 8, 9, 10, 11, 16, 17 18, 19, 20, 21

MEMORANDUM OF POINTS AND AUTHORITIES

The operative First Amended Complaint (“FAC”) alleges that the Chico Unified School District (“District”) is violating the constitutional rights of Plaintiff AURORA REGINO (“Plaintiff”) to direct the upbringing of her children and to freedom from interference in familial relations. Specifically, Plaintiff alleges that Administrative Regulation 5145.3 (“AR 5145.3”) authorizes District personnel to “socially transition” her children without parental notice and consent. However, despite Plaintiff’s assertions, AR 5145.3 does not authorize District employees to “socially transition” students. As explained in the regulation, as well as other submissions to the Court, “social transitioning” is the child’s own decision to adopt a gender expression which aligns with their own, self-determined gender identity – not a third person’s acceptance and use of that child’s preferred transgender name and pronouns. Far from directing students to express themselves in a particular way, AR 5145.3 simply requires District personnel to accept social transitioning decisions a student has already made, and to keep that information confidential from parents if requested by the student unless disclosure is otherwise permissible such as for the safety of the child.

Moreover, the United States Court of Appeals for the Ninth Circuit (“Ninth Circuit”) has repeatedly held that the right of a parent to direct the upbringing of a child (1) does not usurp the constitutionally-recognized right of privacy held by that child; (2) does not empower a parent or guardian to impose their own gender identity preferences upon the child; nor (3) empowers a parent or guardian to impose their own curriculum preferences upon a public school district. Likewise, precedent further provides that the right of freedom from interference in familial relations is limited to matters of State efforts to (1) physically separate a child from their parent, and/or (2) retaliate against one for the conduct of the other. A public entity maintaining the confidentiality of a child’s gender identity which the child themselves is already keeping confidential from the parent does not constitute an unlawful interference in familial relations.

Finally, Ninth Circuit precedent further provides that Plaintiff’s procedural due process claims must fail because AR 5145.3 is a rule generally applicable to the public, not individual persons; and therefore, Plaintiff is not constitutionally entitled to individual notice and hearing.

For these reasons, the Court should grant the instant motion, and dismiss all causes of action raised in the FAC.

PERTINENT BACKGROUND

Defendant KELLY STALEY is the Superintendent of the District. Dkt., “First Amended Complaint,” Apr. 10, 2023 (ECF 42) (“FAC”), ¶ 25. In her position, Defendant Staley is responsible for overseeing implementation of District policies. FAC, ¶ 25.

Plaintiff AURORA REGINO is the mother of A.S. and C.S., minor students who attend District schools. FAC, ¶¶ 4, 16. During the 2021-2022 school year, A.S. attended an elementary school operated by the District. FAC, ¶ 4.

AR 5145.3 sets forth how the District will comply with applicable state and federal civil rights laws concerning discrimination, harassment, intimidation, and bullying based upon any protected category, including race, color, and ancestry, among others. Request for Judicial Notice (“RJN”) No. 1. As of the 2021-2022 school year, AR 5145.3 read, in pertinent part:

Gender transition refers to the process in which a student changes from living and identifying as the sex assigned to the student at birth to living and identifying as the sex that corresponds to the student’s gender identity.¹ ...

1. Right to privacy: A student's transgender or gender-nonconforming status is the student’s private information and the district shall only disclose the information to others with the student's prior written consent....
6. Names and Pronouns: If a student so chooses, district personnel shall be required to address the student by a name and the pronoun(s) consistent with the student’s gender identity, without the necessity of a court order or a change to the student’s official district record. ...

RJN, No. 1 [at pp. 4-7]. In turn, the FAC alleges, in pertinent part:

64. ...A.S. went to [school counselor] 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

¹ See also, Dkt., “Declaration of Jack Turban,” Feb. 14, 2023 (ECF 22-3) (at para. 19, defining “social transition”); RJN No. 2 (WPATH SOC 8, at p. S253) (defining “transition”).

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." Ms. Robertson asked A.S. if she wanted her mother to be informed about her new identity at school, and A.S. said she did not. At the time, A.S. ... thought that her mother would be "mad" at her for wanting to identify as a boy. ...

66. 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. In addition, pursuant to [AR 5145.3] Ms. Robertson and/or A.S.'s teacher arranged for other school personnel to begin referring to A.S. by "J.S." and male pronouns, which they did.

67. Once A.S. told Ms. Robertson she "felt like a boy," 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. ...

68. Over the course of the spring semester of 2022, A.S. had approximately two additional one-on-one meetings with Ms. Robertson. At these meetings, Ms. Robertson provided A.S. with additional resources regarding her supposed new male identity, such as referring A.S. to a local community group that advocates for LGBTQ+ causes and discussing "top surgery" and "breast binding" with her.

69. A.S. told Ms. Robertson that she wanted to tell her mother about her new male identity, but Ms. Robertson was not supportive of this course of action. [Ms. Robertson] ... encouraged [A.S.] to speak with other family members before telling her mother.

70. During this time, pursuant to [AR 5145.3], school personnel and students 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. ...

FAC, ¶¶ 64, 66-70 (emphasis in original, footnotes omitted).

Based upon these allegations, Plaintiff raises substantive due process, procedural, and

First Amendment challenges to AR 5145.3. FAC, ¶¶ 99-133.

ARGUMENT

I. THE FAC FAILS TO STATE FACTS CONSTITUTING A FACIAL VIOLATION OF PLAINTIFF’S SUBSTANTIVE DUE PROCESS RIGHTS

A. Plaintiff Fails to Allege the Deprivation of a Right Secured by Federal Law

Count One raises a claim under title 42, United States Code section 1983 (“Section 1983”), alleging that AR 5145.3 facially violates Plaintiff’s substantive due process rights. FAC, ¶¶ 99-106. To state a claim under Section 1983 alleging a violation of substantive due process, the complainant must establish a “deprivation of life, liberty, or property.” *Brittain v. Hansen*, 451 F.3d 982, 991 (9th Cir. 2006) (internal grammatical marks and citation omitted). In addition, the complainant must also establish a “cognizable level of executive abuse of power as that which shocks the conscience.” *Id.* (internal grammatical marks and citations omitted). Finally, “[a] facial challenge to a [policy] is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the [policy] would be valid.” *United States v. Salerno*, 481 U.S. 739, 745 (1987).

i. Parents Do Not Have a Right to Impose their Gender Identity Preferences

Here, with regard to the “deprivation of life, liberty, or property” element, Count One alleges that AR 5145.3 denies Plaintiff of her right to direct the upbringing of A.S. FAC, ¶¶ 100-101. Indeed, parents do hold a liberty interest in making decisions concerning the care, custody, and control of their children. *Fields v. Palmdale Sch. Dist.*, 427 F.3d 1197, 1204 (9th Cir. 2005). However, Plaintiff contends that her rights include the authority to decide for herself whether A.S. will become transgender, and that her child might have no say in the matter:

[AR 5145.3] *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...; ...

[AR 5145.3] *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*

FAC, ¶ 101 (emphasis added, quoted language from subparagraphs (a), (f)).

The question, therefore, is whether a parent does have a constitutional right to know their child's gender identity, and compel their own identity preferences upon the child. To that end, the federal constitution provides individuals a right of privacy concerning personal information. *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977). This right applies to the sex lives of students with regard to their parents. For example, in *C.N. v. Wolf*, 410 F.Supp.2d 894, 903 (C.D. Cal. 2005), the Court found that a minor student had raised a valid claim of invasion of privacy by asserting that the school district had disclosed her sexual orientation to a parent without the student's consent. See also, *Nguon v. Wolf*, 517 F.Supp.2d 1177, 1191, 1195-96 (C.D. Cal. 2007) (citing *Sterling v. Borough of Minersville*, 232 F.3d 190, 196 (3d Cir. 2000)).

More recently, a federal district court specifically held that minor students also have a privacy right to maintain their gender identities a secret from their parents. *John & Jane Parents I v. Montgomery Cnty. Bd. of Educ.* (“*J&J Parents*”), 2022 U.S. Dist. LEXIS 149021 (D. Md. Aug. 18, 2022) (appeal pending). While this particular federal court represented the District of Maryland, it relied heavily upon the Ninth Circuit's *Fields* analysis in coming to its determination. *Id.*, at *26, 34-35. The court found that maintaining a “student's gender identity confidential unless and until that student consents to disclosure ... both protect[s] the student's privacy and create[s] ... a zone of protection ... in the hopefully rare circumstance when disclosure of the student's gender expression while at school could lead to serious conflict within the family, and even harm.” *Id.* at *38-39. Indeed, gender identity, in general, has long been considered information subject to the right of privacy in the Ninth Circuit. *Nelson v. NASA*, 568 F.3d 1028, 1037-38 (9th Cir. 2009) (J. Wardlaw concurring); see also *Sterling*, 232 F.3d at 196 (“It is difficult to imagine a more private matter than one's sexuality and a less likely probability that the government would have a legitimate interest in disclosure of sexual identity.”)

A month after the *J&J Parents* decision, a New Hampshire Superior Court likewise found that minor students have a privacy right to maintain their gender identity a secret from their parents. Finding such a right attune to previous federal court decisions, including the right of minor students to keep private their use of a school's birth control clinic, *Doe v. Irwin*, 615

F.2d 1162, 1168-69 (6th Cir. 1980), and conversations with a school counselor, *Thomas v. Evansville-Vanderburgh Sch. Corp.* 258 Fed.Appx. 50, 52-54 (7th Cir. 2007), the New Hampshire court emphasized that “the Policy does not prevent parents from observing their children’s behavior...; talking to their children; providing religious or other education to their children; choosing where their children live and go to school; obtaining medical care and counseling for their children; monitoring their children’s communications...; choosing with whom the children socialize; and deciding what their children may do in their free time. In short, the Policy places no limits on the plaintiff’s ability to parent her child as she sees fit.” Order, *Jane Doe v. Manchester Sch. Dist.*, Case No. 216-2022-CV-00117, at *6-7 (N.H. Superior Court, Hillsborough County, Northern District, Sept. 5, 2022); RJN No. 3.

In short, every court known to the District to consider the question has found that a child has a right of privacy as to their gender identity which supersedes any desire of a parent (1) to know, let alone (2) impose their own gender identity preferences upon the child.

ii. Parents Do Not Have a Right to Impose their Curriculum Preferences

In addition, case law has long established that parents have no right to impose their preferences as to how school districts educate their students. “[O]nce parents make the choice as to which school their children will attend, their fundamental right to control the education of their children is, at the least, substantially diminished,” and “they do not have a fundamental right generally to direct *how* a public school teaches their child.” *Fields*, 427 F.3d at 1206 (emphasis in original). While “parents have a right to inform their children when and as they wish on the subject of sex, they have no constitutional right . . . to prevent a public school from providing its students with whatever information it wishes to provide, sexual or otherwise, when and as the school determines that it is appropriate to do so.” *Parents for Privacy v. Barr*, 949 F.3d 1210, 1231 (9th Cir. 2020) (internal grammatical marks and citation omitted).

In other words, the scope of a parent’s right to direct the educational upbringing of their child, which would include teacher-student conversations concerning gender identity, generally stops at the schoolhouse door. Plaintiff exercised her right to direct the educational upbringing of A.S. by choosing to enroll her child in the District. Upon Plaintiff making that decision, it was

the District's decision as to what curriculum and extracurricular activities would be afforded her child. In turn, it was A.S.'s own personal decision whether to inform Plaintiff of her new gender identity. The law requires the District to respect that decision absent circumstances such as concern for the safety of the child.

iii. Parents Do Not Have a Right to Notice and Consent to Treatment

Finally, case precedent is clear, the federal Constitution does not empower parents with a right to notice and/or consent of medical and psychological care their minor children voluntarily seek. For example, as discussed above, federal circuit courts have recognized that minor students have the right to keep private their use of a school's birth control clinic, *Irwin*, 615 F.2d at 1168-69, and conversations with a school counselor, *Thomas*, 258 Fed.Appx. at 52-54. Indeed, any State-mandated rule requiring parental notice and/or consent is unconstitutional unless it survives strict scrutiny. *Nunez by Nunez v. City of San Diego*, 114 F.3d 935, 945-46 (9th Cir. 1997) (any rule treating minors differently raises strict scrutiny review). To that end, "when the minor is mature enough to make her own [medical] decisions independent of her parents, the State has no more interest in notifying her parents than it would in notifying the parents of an adult woman -- namely, none." *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F. Supp. 2d 1012, 1019 (D. Idaho 2005). "The State runs afoul of the Constitution ... when it attempts to give that same power [of consent] to parents of mature daughters capable of making their own informed choices. Because maturity does not always correspond to the age of majority, minors must have the chance to demonstrate their maturity." *Planned Parenthood v. Miller*, 63 F.3d 1452, 1460 (8th Cir. 1995). Thus, for example, the United States Supreme Court requires that any State-compelled, parental consent requirement for an abortion must include a provision permitting the minor to "bypass" the requirement if they are mature enough to make their own decisions. *Bellotti v. Baird*, 443 U.S. 622, 653-54 (1979).

Indeed, even so-called "immature" minors maintain constitutional protections. "A child, merely on account of his minority, is not beyond the protection of the Constitution. As the Court said in *In re Gault*, 387 U.S. 1, 13 (1967), 'whatever may be their precise impact, neither the Fourteenth Amendment nor the Bill of Rights is for adults alone.'" *Bellotti*, 443 U.S. at 633.

“The Court's concern for the vulnerability of children is demonstrated in its decisions dealing with minors’ claims to constitutional protection against deprivations of liberty or property interests by the State. With respect to many of these claims, we have concluded that the child’s right is virtually coextensive with that of an adult.” *Id.* at 634. Given these constitutional protections, while at the same time “recogni[zing] that, during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them,” the United States Supreme “Court has held that the States validly *may* limit the freedom of children to choose for themselves in the making of important affirmative choices with potentially serious consequences,” but only if the limitation survives strict scrutiny by way of the State establishing (1) a compelling interest for doing so, and (2) that the means are narrowly tailored. *Id.* at 635 (emphasis added); *Nunez by Nunez*, 114 F.3d at 945-46 (strict scrutiny). Thus, while States *may* impose limitations upon when minors can make their own decisions if such regulations can survive strict scrutiny, there is certainly no constitutional mandate *requiring* them to do so – especially in the form of parental notice and consent requirements.

For all of these reasons, Plaintiff cannot establish the “deprivation of life, liberty, or property” element of her Section 1983 substantive due process claim.

B. Plaintiff Fails to Allege District Conduct that “Shocks the Conscience”

In addition, Plaintiff further fails to allege facts of District conduct that “shocks the conscience.” “[W]e consider conduct to be conscience-shocking if it was taken with deliberate indifference toward a plaintiff’s constitutional rights.” *Sylvia Landfield Trust v. City of Los Angeles*, 729 F.3d 1189, 1195 (9th Cir. 2013). “[C]onduct intended to injure in some way unjustifiable by any government interest is the sort of official action most likely to rise to the conscience-shocking level....” *Cnty. of Sacramento v. Lewis*, 523 U.S. 833, 849 (1998).

Here, as discussed above, there has been unanimity in court decisions holding that students have a controlling, constitutional right to privacy concerning their sex and gender information. In addition, as discussed in connection with the preceding motion for preliminary injunction, the California Department of Education (“CDE”) has issued guidance pursuant to its

statutory authority under California Education Code section 33308.5, subdivision (a), that California law requires the District to accept the direction of students regarding their gender identity – including requests concerning the confidentiality of that information. RJN No. 4 [FAQ Nos. 6-8]. Thus, given the unanimity of case decisions on this question, and the direction of the CDE, the fact that the District’s regulation simply requires it to respect the gender identity and privacy wishes of its students does not constitute “deliberate indifference” towards any purported parental rights in a manner that “shocks the conscience.” Also, the regulation expressly provides for circumstances where parental disclosure is permissible such as for the safety of the child.

Moreover, again, the federal court in *J&J Parents* found that maintaining a “student’s gender identity confidential unless and until that student consents to disclosure ... create[s] ... a zone of protection . . . in the hopefully rare circumstance when disclosure of the student's gender expression while at school could lead to serious conflict within the family, and even harm.” 2022 U.S. Dist. LEXIS 149021 at *38-39. Given the *parens patriae* governmental interest in protecting minors from domestic violence, *Mueller v. Aufer*, 700 F.3d 1180, 1186-87 (9th Cir. 2012); any emotional distress Plaintiff may have collaterally incurred as a result of the District protecting its students from potential physical harm fails the “shocks the conscious” standard.

C. Plaintiff Cannot Show AR 5145.3 Would Be Invalid in Every Circumstance

Finally, as noted above, “[a] facial challenge to a [policy] is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the [policy] would be valid.” *Salerno*, 481 U.S. at 745. Here, given that there are unquestionably circumstances in which disclosing a student’s gender identity to a parent or guardian will “lead to serious conflict within the family, and even harm,” as found in *J&J Parents*, 2022 U.S. Dist. LEXIS 149021 at *38-39; and given that the Supreme Court expressly held in *Bellotti*, 443 U.S. at 633 that mature minors have the right to bypass any parental notice requirement, Plaintiff cannot satisfy the *Salerno* standard of establishing that AR 5145.3 would be invalid in every conceivable circumstance.

D. AR 5145.3 Satisfies Rational Basis Review

When a substantive due process claim does not involve a fundamental right, rational basis

review applies. *Witt v. Dep't. of the Air Force*, 527 F.3d 806, 817 (9th Cir. 2008). Such review only requires the rule in question to bear a “reasonable relation to a legitimate state interest.” *Washington v. Glucksberg*, 521 U.S. 702, 722 (1997). Here, as discussed in *J&J Parents*, 2022 U.S. Dist. LEXIS 149021 at *39, the District has a legitimate state interest to protect the student’s privacy and create a zone of protection from potential domestic abuse. Maintaining the confidentiality of a student’s gender identity has a reasonable relationship with that interest.

Accordingly, for all of these reasons, Count One fails to state facts raising a legally-cognizable claim, and should be dismissed by the Court.

II. THE FAC FAILS TO STATE FACTS CONSTITUTING AN AS-APPLIED VIOLATION OF PLAINTIFF’S SUBSTANTIVE DUE PROCESS RIGHTS

Count Two alleges the same substantive due process claim as Count One, except it raises an as-applied challenge to AR 5145.3 rather than a facial one. FAC, ¶¶ 107-113. An “as-applied attack ... challenges only ... a subset of the statute’s applications, or the application of the statute to a specific factual circumstance, under the assumption that a court can separate valid from invalid subrules or applications.” *Hoye v. City of Oakland*, 653 F.3d 835, 857 (9th Cir. 2011) (internal grammatical marks and citation omitted). “The underlying constitutional standard, however, is no different then [sic] in a facial challenge.” *Legal Aid Servs. of Or. v. Legal Servs. Corp.*, 608 F.3d 1084, 1096 (9th Cir. 2010). Thus, to prevail in Count Two, Plaintiff must still establish a “deprivation of life, liberty, or property,” as well as a “cognizable level of executive abuse of power as that which shocks the conscience.” *Brittain*, 451 F.3d at 991 (internal grammatical marks and citations omitted). The only difference for this as-applied challenge is that Plaintiff need not establish that AR 5145.3 is unlawful in every conceivable circumstance, but only that it was applied to her, specifically, in an unconstitutional manner.

Here, with regard to the purported “gender transitioning,” the FAC first alleges that the District instructed its students to “explore their sexual identities and consider whether they felt like they were not the gender associated with their sex.” FAC, ¶ 58; see also FAC, ¶ 67. Again, however, a school’s curriculum choices do not interfere with a parent’s right to raise their children. *Barr*, 949 F.3d at 1231; *Fields*, 427 F.3d at 1206. From there, the FAC admits that A.S.

“began feeling like she might be a boy.” FAC, ¶ 60. Notably, the FAC does not allege that it was the District who instructed or suggested to A.S. that she “might be a boy.” The FAC then admits that “A.S. went to Ms. Robertson’s office to tell her that she ‘felt like a boy’....” FAC, ¶ 64. In other words, the pleading admits that it was A.S. who approached District personnel regarding her gender identity, not vice-versa.

Next, the pleading admits that Ms. Robertson responded by simply “ask[ing] 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.” FAC, ¶ 64. Notably, the FAC does not allege that Ms. Robertson directed A.S. that she must do so. While the FAC alleges that A.S. “felt pressured” by this simple request, nothing in the FAC suggests that Ms. Robertson’s question would “shock the conscience” – especially in light of the CDE guidance requiring school districts to address transgender students in the manner the student prefers. FAC, ¶ 64. The FAC then admits that A.S. “responded in the affirmative and told Ms. Robertson her boy’s name was ‘J.S.’” FAC, ¶ 64. In other words, A.S. had already chosen her own identity, not the District. The FAC then provides that “[a]fter the meeting, Ms. Robertson walked A.S. to her class 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,” in line with the CDE guidelines and AR 5145.3 requirements. FAC, ¶ 66.

In addition, the FAC alleges that “[o]ver the course of the spring semester of 2022, A.S. had approximately 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 ‘top surgery’ and ‘breast binding’ with her.” FAC, ¶ 68 (footnotes omitted). Notably, however, as to the former, the pleading merely alleges that Ms. Robertson notified A.S. of a local community group to which she might be interested. The FAC does not allege that Ms. Robertson directed A.S. to join, visit, or even review the group as a mandatory requirement. As to the latter, the pleading notably does not allege who started the purported conversations regarding “top surgery” and “breast binding,” how brief those discussions may have been; nor, if Ms. Robertson’s contribution to the conversations included anything more than general support for

A.S. In other words, the FAC does not raise any factual allegations regarding the manner in which the District allegedly “gender transitioned” A.S. that diverged from the AR 5145.3 framework requiring this Court to consider additional factors in this “as applied” challenge beyond those relevant to the “facial” analysis above – an analysis that establishes that the pleading fails to raise a cognizable substantive due process claim.

With regard to maintaining the confidentiality of A.S.’s gender identity, the FAC admits that during the aforementioned meeting, “Ms. Robertson asked A.S. if she wanted her mother to be informed about her new identity at school, and A.S. said she did not. At the time, A.S. ... thought that her mother would be ‘mad’ at her for wanting to identify as a boy.” FAC, ¶ 64. In other words, again, it was A.S. who directed the District to keep their gender identity confidential from Plaintiff, not the other way around. The FAC then alleges that sometime later “A.S. told Ms. Robertson that she wanted to tell her mother about her new male identity, but Ms. Robertson was not supportive of this course of action. [Ms. Robertson] ... encouraged [A.S.] to speak with other family members *before* telling her mother. ... On or about April 8, 2022, A.S. told her grandmother about her new gender identity. A.S.’s grandmother informed [Plaintiff] of the news later that day.” FAC, ¶¶ 69, 72. Notably, the pleading does not allege that the District directed, nor even advised, A.S. to keep their gender identity secret from Plaintiff. Rather, the FAC admits that the District simply “*encouraged*” A.S. to “speak with other family members *before* telling her mother,” with the unsurprising result that those family members would likely notify Plaintiff before A.S. did so, themselves. Again, the District has a governmental interest in protecting its students from hostile reactions by family members – and, again, “[a]t the time, A.S. ... thought that her mother would be ‘mad’ at her for wanting to identify as a boy.” FAC, ¶ 64.

Thus, like the “social transitioning” allegations, those alleging the District encouraged A.S. to tell other family members of her gender identity “*before*” discussing the matter with their mother do not establish that the District acted in a way divergent from AR 5145.3 requiring this Court to consider any additional factors in this “as applied” challenge beyond those relevant to the “facial” analysis above. In turn, whereas the facial analysis above establishes that the District did not violate any substantive due process rights, the Court should dismiss Count Two, as well.

III. THE FAC FAILS TO STATE FACTS CONSTITUTING A VIOLATION OF PLAINTIFF'S PROCEDURAL DUE PROCESS RIGHTS

Counts Three and Four raise additional Section 1983 claims asserting facial and as-applied violations of Plaintiff's procedural due process rights. FAC, ¶¶ 114-122. However, "[t]he first inquiry in every [procedural] due process challenge is whether the plaintiff has been deprived of a protected interest in 'property' or 'liberty.'" *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 59 (1999). "Only after finding the deprivation of a protected interest do we look to see if the State's procedures comport with due process." *Id.* To that end, as discussed above, AR 5145.3 does not infringe upon Plaintiff's right to direct the upbringing of her child. Accordingly, on this ground alone, the Court should dismiss Counts Three and Four.

Moreover, the Supreme Court has long held that when a public entity deprives a person of a liberty interest through legislative action, that person is not entitled to any procedural due process beyond the standard legislative process. *Bi-Metallic Inv. Co. v. State Bd. of Equalization*, 239 U.S. 441, 445-46 (1915). This fact has been repeatedly recognized by District Courts within the Ninth Circuit, as well as outside federal appellate courts. For example, the Eleventh Circuit Court of Appeal, citing *Bi-Metallic*, has recently explained, "[i]n deciding what the Due Process Clause requires when the State deprives persons of life, liberty or property, the Supreme Court has long distinguished between legislative and adjudicative action. The State often deprives persons of liberty or property through legislative action – general laws that apply to more than a few people. When the state does so, the affected persons are not entitled to *any* process beyond that provided by the legislative process." *Jones v. Governor of Fla.*, 975 F.3d 1016, 1048 (11th Cir. 2020) (emphasis in original, grammatical marks and citation omitted). Likewise, the Eastern District of California, recently found that "[w]ith respect to Procedural Due Process, assuming that Plaintiffs have a protected liberty interest, under *Halverson v. Skagit Cnty*, 42 F.3d 1257 (9th Cir. 1994), 'governmental decisions which affect large areas and are not directed at one or a few individuals do not give rise to the constitutional procedural due process requirements of individual notice and hearing.' Rather, for actions that apply to the public in general, due process is satisfied when officials perform their responsibilities in the normal manner prescribed

by law.” *Culinary Studios, Inc. v. Newsom*, 517 F.Supp.3d 1042, 1052 (E.D. Cal. 2021).

Here, the FAC lacks any allegation that the District enacted AR 5145.3 pursuant to some manner prohibited by law. See generally, FAC. Accordingly, on this additional, independent ground, the Court should dismiss both of Plaintiff’s procedural due process claims.

IV. THE FAC FAILS TO STATE FACTS CONSTITUTING A FACIAL VIOLATION OF PLAINTIFF’S INTIMATE HUMAN RELATIONSHIP RIGHTS

Count Five raises a claim under Section 1983, asserting that AR 5145.3 facially violates Plaintiff’s “intimate human relationship” rights allegedly protected by the First Amendment to the United States Constitution. FAC, ¶¶ 123-128. The Supreme Court has recognized a right to “enter into and maintain certain intimate human relationships” free from “undue intrusion by the State.” *Roberts v. U.S. Jaycees*, 468 U.S. 609, 617-18 (1984). A parent-child relationship is one such protected relationship. *Wallis v. Spencer*, 202 F.3d 1126, 1136 (9th Cir. 2000). However, this right is protected by the Due Process Clause of the Fourteenth Amendment, not the First Amendment. *IDK, Inc. v. Cnty. of Clark*, 836 F.2d 1185, 1192-93 (9th Cir. 1988). Accordingly, it is subject to the same “shock the conscience” standard discussed above.

To that end, in the parent-child context, the “intimate human relationship” right has only been recognized in two contexts to the knowledge of the District. First, the right of a parent and child to physically live and/or congregate together has been recognized. See e.g., *Hameetman v. City of Chicago*, 776 F.2d 636, 642 (7th Cir. 1985). Second, the right has been recognized where the parent or child suffers retaliation because of the other’s conduct. See e.g., *Agostino v. Simpson*, 2012 U.S. Dist. LEXIS 207375, *26-27 (S.D.N.Y. Mar. 29, 2012). Efforts to otherwise expand this right have been rejected. For example, in *Bovee v. Broom*, 2012 U.S. Dist. LEXIS 15314 (S.D. Ill. Feb. 7, 2012), the Court dismissed a claim alleging that a guidance counselor violated the familial right by telling a child that their parent was “bad at being a father,” finding that the accused conduct did not satisfy the “shock the conscience” standard. Similarly, in *Hernandez v. Cnty of Alameda*, 2023 U.S. Dist. LEXIS 11260, *28-30 (N.D. Cal. Jan. 23, 2023), the Court dismissed a claim raised by a child that the familial right had been violated by the failure to provide adequate medical care to their parent, leading to that parent’s death.

Here, the FAC does not allege that the District has done anything to physically separate A.S. from Plaintiff. Nor, do the allegations allege any act of retaliation. Indeed, the allegations do not establish any purported interference of any kind – and certainly not one that would “shock the conscience.” Rather, the District is simply alleged to have kept information confidential from Plaintiff that A.S. was already keeping confidential from her. In other words, the District simply maintained the status quo at the request of A.S. As such, the FAC fails to raise a legally-cognizable claim of any unconstitutional interference with Plaintiff’s familial rights.

V. THE FAC FAILS TO STATE FACTS CONSTITUTING AN AS-APPLIED VIOLATION OF PLAINTIFF’S INTIMATE HUMAN RELATIONSHIP RIGHTS

Finally, Count Six alleges the same due process claim as Count Five, except it raises an as-applied challenge rather than a facial one. FAC, ¶¶ 129-133. Thus, to prevail in Count Six, Plaintiff must still establish a “deprivation of life, liberty, or property,” as well as a “cognizable level of executive abuse of power as that which shocks the conscience.” *Brittain*, 451 F.3d at 991 (internal grammatical marks and citations omitted). For the reasons discussed above, she cannot do so. In addition, again, the FAC admits that during their aforementioned meeting, “Ms. Robertson asked A.S. if she wanted her mother to be informed about her new identity at school, and A.S. said she did not.” FAC, ¶ 64. As such, again, it was A.S. who directed the District to keep their gender identity confidential from Plaintiff, not the other way around. Thus, the allegations concerning the District maintaining the confidentiality of A.S.’s gender identity do not establish that the District acted in a way divergent from AR 5145.3 requiring this Court to consider any additional factors in this “as applied” challenge beyond those relevant to the “facial” analysis above – an analysis that establishes that the pleading fails to raise a cognizable due process claim. As such, the Court should dismiss Count Six, as well.

Dated: April 25, 2023

LEONE ALBERTS & DUUS

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AURORA REGINO

**IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA**

AURORA REGINO,

Plaintiff,

vs.

**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.: 2:23-cv-00032-JAM-DMC

FIRST AMENDED COMPLAINT

JURY TRIAL DEMANDED

1 Plaintiff, Aurora Regino, by and through her undersigned counsel, hereby states the
2 following claims for relief against Defendants, each in their official capacity only, and
3 respectfully requests that this Court render a declaratory judgment and issue a permanent
4 injunction against Defendants' ongoing violations of the United States Constitution as set forth
5 herein.¹ In support thereof, Ms. Regino alleges as follows:

6 **INTRODUCTION**

7 1. The United States Constitution protects parents' fundamental right to direct and
8 control the upbringing of their children. This right includes the right of parents to direct and
9 control the decision-making process regarding whether a public school will "socially transition"
10 their minor children from one gender to another.

11 2. "Social transitioning" refers to the active affirmation of a person's transgender
12 identity. In the school setting, it primarily refers to calling the student by a new name associated
13 with their transgender identity and referring to the student by pronouns associated with their
14 transgender identity. Social transitioning is a powerful psychological intervention affecting a
15 matter of major importance to a minor's life that implicates the integrity of the family. Under the
16 United States Constitution, public schools may not socially transition minors without first
17 informing and receiving consent from their parents.

18 3. The Chico Unified School District (the "District" or "Defendants") has adopted an
19 administrative regulation (the "Parental Secrecy Policy" or the "Policy") under which schools in
20 the District will (1) socially transition any student who claims to have a transgender identity and
21 asks to be socially transitioned in the school environment and (2) keep the social transitioning
22 secret from the student's parents unless the student specifically authorizes the school to inform
23 them. Schools in the District are prompting students to question their sexuality and gender and,
24 under the Parental Secrecy Policy, employing the coercive machinery of the state to socially
25 transition students who assert a transgender identity, all without informing the students' parents
26

27
28 ¹ Ms. Regino files this First Amended Complaint as a matter of right pursuant to Federal Rule of
Civil Procedure 15(a)(1)(B).

1 or obtaining parental consent. Even if the parents would be supportive of their children—as Ms.
2 Regino was here—the Parental Secrecy Policy precludes parents from being a part of this
3 monumental decision in their children’s lives based on nothing more than the child’s say so.

4 4. Ms. Regino’s oldest daughter, A.S., was a fifth-grade student at an elementary
5 school operated by the District during the 2021–2022 school year. In early 2022, when A.S. was
6 eleven years old, she informed a school counselor that she “felt like a boy.” Within minutes of
7 A.S. making that statement, the counselor asked A.S. if she had a boy name she would like to be
8 called and whether she would like to be referred to with male pronouns. A.S. said that she did.
9 After the meeting, the counselor walked A.S. to class and informed A.S.’s teacher about A.S.’s
10 new identity, name, and pronouns. Thereafter, the District, through deliberate governmental
11 action and threat of sanction for non-compliance, required everyone in the school environment—
12 administrators, teachers, and other students—to refer to A.S. by her new name and pronouns.
13 Despite the role the District played in socially transitioning A.S., the District kept its actions secret
14 from A.S.’s mother, Ms. Regino.

15 5. Social transitioning is a significant form of psychological treatment. Indeed, the
16 very purpose of social transitioning is to alleviate the psychological distress that can be caused by
17 a mismatch between one’s body and gender identity by affirming the transgender identity. The
18 District, however, lacked both the competence and parental consent necessary to administer this
19 treatment to A.S. As a minor child, A.S. was not capable of giving her own consent.

20 6. The decision of whether to socially transition a child at school is a monumental
21 decision in the life of the child. It has long-term consequences that will drastically impact the
22 child’s life course, and it implicates the integrity of the family unit, altering intimate interpersonal
23 relationships between parents and their “sons” or “daughters.”

24 7. Despite these facts, the District, acting pursuant to the Parental Secrecy Policy, cut
25 Ms. Regino out of the decision-making process, arrogating to itself and A.S. the authority to make
26 these decisions on their own. By doing so, the District treated A.S. as a mere creature of the state
27 and in a manner that is repugnant to the American tradition.

28 8. After several weeks of the District treating Ms. Regino’s daughter as if she were a

1 boy, Ms. Regino learned about the District's actions and A.S.'s supposed new gender identity.
2 Ms. Regino was supportive of A.S. but upset that the school had not even informed her that it was
3 socially transitioning her daughter. She tried to encourage the District to abandon the Parental
4 Secrecy Policy in favor of a policy that would involve parents in students' social transitioning,
5 but she was told that the Policy is required by California law. This is false.

6 9. Despite the District's efforts to socially transition A.S. to a boy, A.S. has, for now,
7 returned to identifying as a girl. She now believes her feelings of gender confusion were brought
8 on by a confluence of factors, including the stress of other external difficulties in her life and the
9 District's promotion of transgender identities. She now attends regular counseling sessions with
10 a private therapist to help her to cope with the stressors in her life.

11 10. By socially transitioning A.S. without informing Ms. Regino or obtaining her
12 consent, the District violated Ms. Regino's fundamental right to direct and control the upbringing
13 of her child. Parents, not schools, have the right—and responsibility—to make decisions
14 regarding their minor children's medical and psychological treatment, the major decisions in their
15 children's lives, and decisions that implicate the integrity of their family. These rights are
16 infringed when schools socially transition children from one gender to another without informing
17 their parents and obtaining their consent to do so.

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

24 12. Upon receiving notice of this lawsuit, the District initially denied in written
25 correspondence to parents that it even had a Parental Secrecy Policy. *See* "A Message from the
26 CUSD Superintendent," dated January 13, 2023, attached hereto as Exhibit A. At subsequent
27 meetings of the Chico Unified School District Board of Education (the "Board"), however, the
28 District has been forced to admit that the Policy is, in fact, in force. Indeed, at the Board meeting

1 on April 5, 2023, the Board affirmed its commitment to the Parental Secrecy Policy. Ms. Regino
2 thus respectfully requests that the Court enjoin the Parental Secrecy Policy, once and for all,
3 without delay.

4 **JURISDICTION AND VENUE**

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

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

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

10 **THE PARTIES**

11 16. Plaintiff Aurora Regino is a resident of Chico, California. She is a single mother
12 with sole custody over her two minor daughters, A.S. (age twelve) and C.S. (age nine), both of
13 whom live with her. At all relevant times to this Complaint, both A.S. and C.S. attended—and still
14 attend—schools operated by the District.

15 17. Ms. Regino is a fit parent, is actively involved in her children's lives, loves her
16 children dearly, seeks to do what is best for them at all times, and wishes to provide them with
17 the nurturing and guidance of a loving and caring mother in all aspects of their lives. To that end,
18 Ms. Regino engages with her children's schools and other aspects of their lives outside of the
19 family home to ensure that she is informed about what occurs in their lives when they are not in
20 her immediate supervision. She intends to continue this level of involvement in her children's
21 lives.

22 18. The District is a public school district based in Chico, California. It operates
23 twenty-three schools—twelve elementary schools, four junior high schools, three high schools,
24 and four other schools, some of which educate children as young as four years old. *See*
25 <http://www.chicousd.org/Schools/Our-Schools/index.html>, last visited on April 8, 2023, attached
26 hereto as Exhibit B. Over 12,000 students attend school in the District. *See*
27 <http://www.chicousd.org/Our-District/index.html>, last visited on April 8, 2023, attached hereto as
28 Exhibit C.

1 19. The District is governed by the Chico Unified School District Board of Education
2 (the “Board”). *See* <http://www.chicousd.org/Our-District/Board-Trustee-Information/index.html>,
3 last visited on April 8, 2023, attached hereto as Exhibit D. The Board and its five Members are
4 responsible for general oversight and operations of the District. *See id.*

5 20. Defendant Caitlin Dalby is a Member of the Board. *Id.* In this capacity, Ms. Dalby
6 is responsible for general oversight and operations of the District. *Id.* At all times relevant to this
7 Complaint, Ms. Dalby was and will be acting under color of California law while performing her
8 duties as a Board Member. Ms. Dalby is sued in her official capacity only.

9 21. Defendant Rebecca Konkin is a Member of the Board. *Id.* In this capacity, Ms.
10 Konkin is responsible for general oversight and operations of the District. *Id.* At all times relevant
11 to this Complaint, Ms. Konkin was and will be acting under color of California law while
12 performing her duties as a Board Member. Ms. Konkin is sued in her official capacity only.

13 22. Defendant Tom Lando is a Member of the Board. *Id.* In this capacity, Mr. Lando
14 is responsible for general oversight and operations of the District. *Id.* At all times relevant to this
15 Complaint, Mr. Lando was and will be acting under color of California law while performing his
16 duties as a Board Members. Mr. Lando is sued in his official capacity only.

17 23. Defendant Eileen Robinson is a Member of the Board. *Id.* In this capacity, Ms.
18 Robinson is responsible for general oversight and operations of the District. *Id.* At all times
19 relevant to this Complaint, Ms. Robinson was and will be acting under color of California law
20 while performing her duties as a Board Member. Ms. Robinson is sued in her official capacity
21 only.

22 24. Defendant Matt Tennis is a Member of the Board. *Id.* In this capacity, Mr. Tennis
23 is responsible for general oversight and operations of the District. *Id.* At all times relevant to this
24 Complaint, Mr. Tennis was and will be acting under color of California law while performing his
25 duties as a Board Member. Mr. Tennis is sued in his official capacity only.

26 25. Defendant Kelly Staley is the Superintendent of the District. *See*
27 <http://www.chicousd.org/Our-District/Superintendent/index.html>, last visited on April 8, 2023,
28 attached hereto as Exhibit E. In this capacity, Superintendent Staley is responsible for the

1 implementation of all District policies, and the development, adoption, and implementation of all
2 administrative regulations, including the Parental Secrecy Policy, and she has ultimate
3 supervisory authority over all District employees, which includes all employees working at the
4 schools within the District. At all times relevant to this Complaint, Superintendent Staley was and
5 will be acting under color of California law while performing her duties as Superintendent.
6 Superintendent Staley is sued in her official capacity only.

7 **FACTUAL ALLEGATIONS**

8 **Background on Transgender Identities and Gender Dysphoria**

9 26. The terms “sex” and “gender” are not interchangeable. “Sex” refers to an
10 individual’s biological reproductive capabilities, while “gender” refers to the characteristics of
11 women, men, boys, and girls that are socially constructed and mutable.

12 27. A person’s “gender identity” is the person’s internal, felt experience of gender.

13 28. Persons with a “transgender” identity feel that their gender identity does not match
14 their sex.

15 29. “Gender dysphoria” refers to a condition in which the mismatch between an
16 individual’s gender identity and sex produces psychological distress in the individual. Gender
17 dysphoria is a diagnosable psychiatric condition. For the psychological distress to produce gender
18 dysphoria, the distress must be over a certain threshold.

19 30. A person can have a transgender identity without the threshold of associated
20 psychological distress and thus not have gender dysphoria. Nevertheless, a large proportion of
21 minors who have a transgender identity also have developmental and psychiatric conditions such
22 as autism, depression, anxiety, eating disorders, and ADHD. Many also have gender dysphoria.

23 31. Having a transgender identity or gender dysphoria is not biologically determined.

24 32. Minors who claim or express interest in pursuing a transgender identity often do
25 so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of
26 what men and women can be. For example, a male child may feel he has a female gender identity
27 because, in his perception, men like sports and he does not. These minors are unaware of—and
28 simply need to be educated regarding—the vast array of possibilities of how life can be lived as

1 a man or a woman.

2 33. Absent affirmative intervention, a large majority of pre-pubescent children who
3 develop a transgender identity will desist—that is, lose their transgender identity—prior to
4 adulthood.

5 34. Absent affirmative intervention, many post-pubescent children who develop a
6 transgender identity will also desist prior to adulthood, albeit in smaller percentages than pre-
7 pubescent children.

8 35. There are generally four approaches to treating gender dysphoria in children: the
9 “watchful waiting” model, the “hands off” model, the “psychotherapy” model, and the
10 “affirmation” model. There are significant differences in these approaches.

11 36. The “watchful waiting” model seeks to allow for the fluid nature of gender identity
12 in children to evolve naturally. Under this model, the mental health professional treats any other
13 psychological co-morbidities without a focus on gender.

14 37. The “hands off” model is similar to the “watchful waiting” model insofar as it
15 allows the child’s gender identity to evolve naturally, but it provides no ongoing treatment.

16 38. Under the “psychotherapy” model, the mental health professional seeks to identify
17 the causes of the psychological distress and to address those causes through psychotherapy as a
18 means of alleviating the distress.

19 39. The “affirmation” model is starkly different from the other three. It holds that any
20 expression of a transgender identity in the child should be immediately accepted as decisive and
21 permanent.

22 40. A primary pillar of the “affirmation” model is that children who assert a
23 transgender identity and who seek to be socially transitioned should be socially transitioned in
24 order to alleviate any psychological distress associated with the mismatch between the child’s
25 gender identity and sex. In addition, the “affirmation” model assumes that any psychological co-
26 morbidities will improve with the social transition.

27 41. The “affirmation” model—and, specifically, the idea that all children who assert a
28 transgender identity and who seek to be socially transitioned should be socially transitioned—is

1 an impermissible “one-size-fits-all” approach that fails to account for the broader and unique
2 issues the child is facing.

3 42. Social transitioning is not appropriate for every minor child with a transgender
4 identity who expresses a desire to be socially transitioned. For example, as discussed, some
5 children have such a desire due to their stereotypical notions of gender roles. In that situation,
6 education—not social transitioning—is appropriate. Social transitioning in this situation can
7 create psychological complications for the child.

8 43. Social transitioning is not a mere benign intervention; instead, it is a significant
9 form of psychological treatment that substantially *reduces* the number of children who desist from
10 a transgender identity. In other words, socially transitioning children who have a transgender
11 identity makes it significantly more likely that the transgender identity will persist in the child.
12 Living in a transgender identity, which is the result of social transitioning, makes desistence more
13 difficult and significantly less likely.

14 44. In the vast majority of cases where children receive “affirmative” care in the form
15 of social transitioning, the child goes on to receive further “affirmative” care—*i.e.*, puberty
16 blockers and cross-sex hormones, at least. For this reason, before social transitioning is
17 considered, a mental health professional must take account of the risks of this future additional
18 “affirmative” care. These risks are significant, and include bone weakness, cardiovascular harm,
19 depression, increased risk of suicide, decreased sexual response, infertility, sterility, and
20 premature adult mortality, to name a few.

21 45. In light of the first principle of medical ethics (“do no harm”) and based on the
22 risk of iatrogenic harm associated with the “affirmation” method—including the likelihood of
23 inducing persistence and the potential harm of graduated “affirmative” care—the distinct trend in
24 western Europe is a move away from the “affirmation” model as the first approach to treating
25 gender dysphoria in children.

26 46. Regardless of the treatment model, parental involvement is necessary for the
27 responsible, adequate, and ethical assessment, diagnosis, and treatment of children with a
28 transgender identity and gender dysphoria and related conditions. This includes social

1 transitioning. The only exception is when the child is either emancipated or a ward of the state.

2 47. If a minor child's parents are not involved in the process, the child will be unable
3 even to see an appropriate mental health professional on his or her own. Moreover, parents have
4 detailed information about their children's lives, including their medical and psychological
5 history, behaviors, habits, relationships, *etc.*, that provide insight into the child's condition and
6 ongoing needs. In addition, information about the parent-child relationship itself is invaluable in
7 the process. Without all of this information, the mental health professional will be unable to
8 provide an effective assessment, diagnosis, and treatment of the child.

9 48. When a school socially transitions a child in secret from his or her parents, the
10 child inhabits different gender identities at home and school, a situation that is inherently
11 psychologically unhealthy for the child and counterproductive to the child's treatment and mental
12 well-being.

13 49. Schools that socially transition children without their parents' knowledge and
14 consent also violate bedrock principles of medical ethics. Minor children are deemed incapable
15 of making sound judgments regarding their own health care and of understanding the risks
16 associated with it. Even if children could provide informed consent, school personnel lack
17 sufficient knowledge of and training in the complexities and risks in the field to provide sufficient
18 information. And because school personnel lack this knowledge and training, they themselves are
19 unable to adequately determine whether—and what—treatment is necessary. Thus, in order to
20 obtain informed consent for social transitioning, parental involvement is required.

21 50. School personnel lack the necessary education, training, and expertise to enable
22 children (and their parents) to begin to understand what is taking place in the child's mind as a
23 result of social, familial, and individual developmental processes. Far from benefitting students,
24 schools that socially transition minor children without parental knowledge and consent increase
25 transitioned students' anxiety and sense of alienation. The child and the school are colluding to
26 conceal facts from the child's parents, which adds to the student's sense that his or her parents
27 are the "enemy," thus deepening a wedge between parent and child during a formative period in
28 the child's life. Further, social transitioning risks stabilizing what might otherwise be a temporary

1 identity state, thus leading to the further risks of harm discussed above. By socially transitioning
2 children in secret, the school is making a significant decision regarding the child's psychological
3 treatment and well-being that the child's parents and mental health professionals should be
4 making together.

5 **The District's Parental Secrecy Policy**

6 51. The District has adopted and implemented the Parental Secrecy Policy—which is
7 set forth in an administrative regulation that was developed, adopted, and implemented by
8 Superintendent Staley and / or her predecessor in office—at all schools within the District. *See*
9 Administrative Regulation #5145.3, attached hereto as Exhibit F. Under the Parental Secrecy
10 Policy, which is a policy, practice, procedure, and / or custom of the District, schools in the
11 District will (1) socially transition any student who claims to have a transgender identity and asks
12 to be socially transitioned in the school environment and (2) keep the social transitioning secret
13 from the student's parents unless the student specifically authorizes parental notification. *Id.* at
14 5–7.

15 52. Specifically, under the Parental Secrecy Policy, if a student informs District
16 personnel that he or she has a transgender identity and wants to be referred to by a new name and
17 pronouns associated with that identity in the school environment, all District personnel and
18 students are *required* to refer to the student by that name and pronouns. *Id.* at 5 (providing that it
19 shall be a violation of the Parental Secrecy Policy to “[r]efus[e] to address a student by a name
20 and the pronouns consistent with the student's gender identity”). Unless a student who is being
21 socially transitioned specifically authorizes parental disclosure, District personnel are *prohibited*
22 from making such disclosure, except where (1) disclosure is “otherwise required by law” or (2)
23 the District “has compelling evidence that disclosure is necessary to preserve the student's
24 physical or mental well-being.” *Id.*

25 53. Under the Parental Secrecy Policy, the District is authorized to “[t]ak[e]
26 appropriate disciplinary action against students, employees, and anyone determined to have”
27 violated any aspect of the Policy, including but not limited to the requirement that everyone in
28

1 the school environment must refer to students by their new names and pronouns. *Id.* at 3–4. Thus,
2 the Parental Secrecy Policy is enforced by the threat of the coercive power of the state. *Id.*

3 54. The Parental Secrecy Policy is described as a “Nondiscrimination/Harassment”
4 policy, and it does not touch upon the curriculum taught within the District. *Id.* at 1. Instead, it
5 requires the District to perform significant psychological treatment on students, in the form of
6 social transitioning, behind their parents’ backs based on nothing more than the students’
7 statement that they want to be socially transitioned and do not want their parents to be involved,
8 for whatever reason—or no reason at all.

9 **The District’s Actions toward A.S.**

10 55. Ms. Regino’s oldest daughter, A.S., is a twelve-year-old girl. During the 2021–
11 2022 school year, A.S. attended fifth grade at Sierra View Elementary School (“Sierra View”),
12 which is a school within in the District.

13 56. In the fall of 2021, when she was eleven years old, A.S. began feeling depressed
14 and anxious. She had just begun puberty, and there had been significant changes in her home life
15 over the preceding months. Her grandfather had recently passed away and her mother (Ms.
16 Regino) had just completed treatment for breast cancer and was in the process of obtaining a
17 degree in nursing. A.S.’s father is disabled due to an injury from an automobile accident and, as
18 a result of the changes at home, A.S. began taking on a greater role in caring for her younger
19 sister, C.S., who was seven years old at the time. These events left A.S. feeling mentally exhausted
20 and emotionally confused.

21 57. Mandi Robertson was a school counselor at Sierra View. At all times relevant to
22 this Complaint, Ms. Robertson was acting under color of California law while performing her
23 duties as a school counselor.

24 58. Throughout the 2021–2022 school year, Ms. Robertson visited A.S.’s class on a
25 regular basis to remind the class of the services the counselor’s office provided. During these
26 visits, Ms. Robertson frequently brought up the topics of sexuality and gender identity. She would
27 encourage students to explore their sexual identities and consider whether they felt like they were
28 not the gender associated with their sex. She explained that that feeling was normal and that

1 students should embrace the feeling if they had it.

2 59. A.S. took Ms. Robertson's advice. She began wondering if her new feelings of
3 anxiety and depression were because she was born the wrong sex.

4 60. Around December 2021, A.S. began feeling like she might be a boy. These
5 feelings were the result of her exploring her gender identity consistent with Ms. Robertson's
6 instructions.

7 61. In December 2021, before winter break, A.S. met with Ms. Robertson to discuss
8 her feelings of anxiety and depression. At that meeting, A.S. did not mention to Ms. Robertson
9 that she felt like a boy. Ms. Robertson encouraged A.S. to join a small group of other girls around
10 her age that she (Ms. Robertson) would be organizing when school resumed the following month
11 (the "Girls Group"). Ms. Robertson told A.S. that the Girls' Group would be primarily focused
12 on arts and crafts and that the group would be a good opportunity for A.S. to make new friends.
13 Ms. Robertson provided A.S. with a permission slip for participation in the Girls Group for her
14 mother to sign.

15 62. Ms. Regino agreed that an arts-and-crafts group could facilitate positive social
16 interaction for A.S. with other girls her own age and could help A.S. with her anxiety and
17 depression. Ms. Regino signed the permission slip allowing A.S. to participate in the group once
18 school began in the spring semester of 2022. The permission slip was for attendance at the Girls
19 Group only.

20 63. On or about January 20, 2022, A.S. attended her first Girls Group meeting. The
21 meetings included A.S. and about four of her female classmates, whose ages ranged from 10 to
22 12 years old. The first one or two meetings of the Girls Group were geared towards arts and crafts,
23 as A.S. anticipated, but the subject of the meetings quickly changed.

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

25 64. After one or two Girl's Group meetings, A.S. went to Ms. Robertson's office to
26 tell her that she "felt like a boy" or words of similar effect. Ms. Robertson asked A.S. if she had
27 a boy's name that she would like to be called and whether she would like to be referred to by male
28 pronouns. A.S. was unsure whether she wanted others at school to start calling her by a male

1 name and pronouns, but she felt pressured by Ms. Robertson, so she responded in the affirmative
2 and told Ms. Robertson her boy's name was "J.S." Ms. Robertson asked A.S. if she wanted her
3 mother to be informed about her new identity at school, and A.S. said she did not. At the time,
4 A.S. mistakenly thought that her mother would be "mad" at her for wanting to identify as a boy.

5 65. During this meeting, Ms. Robertson did not discuss A.S.'s feelings of anxiety and
6 depression, nor did she attempt to understand the reason(s) behind A.S.'s supposed transgender
7 identity. Instead, the discussion focused solely on how to effect A.S.'s social transition to a boy.

8 66. After the meeting, Ms. Robertson walked A.S. to her class and told her teacher
9 that A.S. was now going by the name "J.S." and male pronouns, and her teacher immediately
10 began referring to her as such. In addition, pursuant to the Parental Secrecy Policy, Ms. Robertson
11 and / or A.S.'s teacher arranged for other school personnel to begin referring to A.S. by "J.S."
12 and male pronouns, which they did.

13 67. Once A.S. told Ms. Robertson she "felt like a boy," the Girls Group meetings
14 changed substantially. Instead of arts-and-craft projects, Ms. Robertson now led A.S. and her
15 female classmates in a discussion regarding sexuality and gender identity. They discussed how to
16 cope with having feelings that one's sex does not match one's gender—specifically, how
17 embracing those feelings and socially transitioning can alleviate the stress and anxiety of living
18 as the "wrong" gender.

19 68. Over the course of the spring semester of 2022, A.S. had approximately two
20 additional one-on-one meetings with Ms. Robertson. At these meetings, Ms. Robertson provided
21 A.S. with additional resources regarding her supposed new male identity, such as referring A.S.
22 to a local community group that advocates for LGBTQ+ causes and discussing "top surgery"²
23 and "breast binding" with her.³

25 ² "Top surgery" refers to a double mastectomy. Females who identify as transgender sometimes
26 have a double mastectomy to appear more masculine.

27 ³ "Breast binding" refers to the flattening of a female's breasts with constrictive clothing to make
28 the chest appear flat. Females who identify as transgender sometimes bind their breasts to appear
more masculine.

69. A.S. told Ms. Robertson that she wanted to tell her mother about her new male 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 before telling her mother.

70. During this time, pursuant to the Parental Secrecy Policy, school personnel and students 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.

71. At no time did Ms. Robertson or anyone at the District inform A.S. (or her mother) that: (1) A.S. should discuss her feelings with a mental health professional; (2) A.S. was free to socially transition back to a girl; (3) A.S. should tell her mother about her social transitioning; or (4) there are risks associated with social transitioning, including the risk of making desistence less likely or the risks associated with graduated affirmative care, nor does the Parental Secrecy Policy require District personnel to make these disclosures to students who are being socially transitioned.

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

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

73. Ms. Regino was surprised to learn of A.S.'s assertion of a transgender identity, 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.

74. Ms. Regino informed A.S. of her support and told her she would assist her with her social 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.

75. Although Ms. Regino was supportive of her daughter, had Ms. Regino been

1 involved in the process, she would not have allowed Sierra View to socially transition her
2 daughter without first seeking guidance from a mental health professional. Ms. Regino arrived at
3 this view for several reasons, including but not limited to: A.S.'s young age and Ms. Regino's
4 perception of her cognitive incapability of understanding what it might mean to have a
5 transgender identity; the quick onset of A.S.'s feelings of gender confusion; the existence of other
6 stressors in A.S.'s life that were the more likely explanation of her feelings of gender confusion;
7 and the short duration of A.S.'s feelings of gender confusion.

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

14 77. Over the rest of the spring semester and summer of 2022, A.S.'s feelings about
15 being a boy continued to subside.

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

17 78. Immediately upon learning that the District had socially transitioned A.S. and kept
18 it secret from her, Ms. Regino contacted Sierra View to report Ms. Robertson's actions and the
19 actions of the other Sierra View employees who were involved in socially transitioning her
20 daughter.

21 79. At the time, Ms. Regino, who was not represented by counsel, did not know about
22 the existence of the Parental Secrecy Policy or that it applied throughout the District. Instead, she
23 assumed—wrongly, as she later learned—that Ms. Robertson and the Sierra View employees who
24 were involved in socially transitioning A.S. were not acting pursuant to District policies.

25 80. Later in April of 2022, after Ms. Regino had spoken with school-level employees,
26 the District's Director of Elementary Education, Ted Sullivan, contacted Ms. Regino and
27 informed her that California law required schools to socially transition students without informing
28 their parents unless the student authorizes them to do so.

1 81. In addition, Mr. Sullivan emailed Ms. Regino a link to an “FAQ” page on the
2 California Department of Education (“DOE”) website regarding Assembly Bill 1266 (“AB
3 1266”). *See* <https://www.cde.ca.gov/re/di/eo/faqs.asp>, last visited on April 8, 2023, attached
4 hereto as Exhibit G. AB 1266 was legislation, now codified at Cal. Ed. Code. § 221.5, designed
5 to prohibit discrimination in schools based on gender identity. Mr. Sullivan informed Ms. Regino
6 that, based on this FAQ page, Sierra View employees had acted consistent with California law.

7 82. The FAQ, however, does not purport to have the force of law, nor does AB 1266
8 (or any other provision of California law) require schools to adopt the Parental Secrecy Policy.
9 Instead, as relevant here, AB 1266 provides only that California public schools must allow
10 students to “participate in sex-segregated school programs and activities . . . and use facilities
11 consistent with his or her gender identity.” *See* Cal. Educ. Code § 221.5(f).

12 83. Ms. Regino informed Mr. Sullivan that she did not interpret either the FAQ or AB
13 1266 to authorize schools to socially transition children without parental notification and consent.

14 84. At that time, Ms. Regino still did not know about the existence of the Parental
15 Secrecy Policy or that it applied throughout the District.

16 85. As the 2021–2022 school year came to a close, Ms. Regino became concerned that
17 (1) District employees at Marsh Junior High School (“Marsh”), the school A.S. would be
18 attending for the 2022–2023 school year, could attempt to socially transition A.S. without
19 informing her, like they had done at Sierra View, and (2) District employees at Sierra View, the
20 school C.S. was attending and would be attending for the 2022–2023 school year, could also
21 attempt to transition C.S. without informing her, as they had done with her sister.

22 86. Disappointed by her prior exchanges with District personnel, Ms. Regino reached
23 out to the District’s Deputy Superintendent, Jay Marchant, to speak with him about what had
24 happened to A.S. and her concerns that it could happen again.

25 87. On or about May 5, 2022, Ms. Regino met with Mr. Marchant. He, like Mr.
26 Sullivan, informed Ms. Regino that Sierra View employees had acted as required by California
27 law. Ms. Regino again disagreed with this assertion.

28 88. On or about August 8, 2022, Ms. Regino again met with Mr. Marchant, this time

1 to seek to transfer her younger daughter, C.S., out of Sierra View and into a different school
2 within the District, away from Ms. Robertson and the other Sierra View employees who had been
3 involved in socially transitioning A.S. On or about August 22, 2022, the District granted Ms.
4 Regino's request, authorizing C.S. to transfer to Parkview, another school within the District.

5 89. Despite the fact Ms. Regino's children were no longer at Sierra View—and what
6 she believed to be an isolated situation there—she continued to press District administration for
7 assurances that what had happened to A.S. would not happen again. On or about October 10,
8 2022, Ms. Regino met with Superintendent Staley to discuss the issue. In that meeting, for the
9 first time, Ms. Regino came to realize that the Parental Secrecy Policy was being applied
10 throughout the District, including at Marsh and Parkview.

11 90. In that meeting, Superintendent Staley informed Ms. Regino that the Parental
12 Secrecy Policy was required by California law. Again, this is false.

13 91. On October 31, 2022, Ms. Regino emailed Superintendent Staley to reiterate her
14 concerns with the Parental Secrecy Policy. On or about November 2, 2022, in response to Ms.
15 Regino's follow-up email, Superintendent Staley confirmed that the District would continue to
16 apply the Parental Secrecy Policy, stating that the District "must work within the confines of the
17 law."

18 92. On or about that same day, Ms. Regino began searching for counsel to assist her
19 in evaluating claims she might have against the District. Ms. Regino engaged the undersigned
20 counsel to bring this lawsuit on or about November 28, 2022.

21 **Ms. Regino's Current and Future Harm**

22 93. The District applies the Parental Secrecy Policy at all of its schools, including but
23 not limited to Marsh and Parkview. Thus, A.S. and C.S. are currently subject to the Parental
24 Secrecy Policy.

25 94. While A.S. now identifies as girl, she is still in counseling for her depression and
26 anxiety. In addition, C.S. is exhibiting traits and behaviors that cause Ms. Regino to believe that
27 C.S., is likely to seek to identify as a boy as she gets older, as her sister did.

28 95. Ms. Regino respects her daughters' life choices and will be supportive of them no

1 matter what those choices ultimately may be, including if they come to have a transgender
2 identity. Ms. Regino is concerned, however, that the District will (again) socially transition her
3 daughters without informing her or obtaining her consent. Ms. Regino simply wants to be
4 involved in her daughters' lives and with the choices that have fundamental importance to them,
5 such as the choice regarding whether to undergo social transitioning, and she is currently suffering
6 psychological distress from her concern that the District will (again) socially transition her
7 daughters behind her back.

8 96. Because the District applies the Parental Secrecy Policy at the schools A.S. and
9 C.S. attend, the Policy presents a real, imminent, and credible threat to her parental right to direct
10 and control their upbringing insofar as it operates to keep decisions regarding her children's social
11 transitioning secret from her and allows such decisions to be made without her involvement.

12 97. Further, the District has steadfastly refused to disavow the Parental Secrecy Policy,
13 both in communications with Ms. Regino directly and in Board meetings held after Ms. Regino
14 filed this lawsuit.

15 98. Ms. Regino is subject to a real, imminent, and realistic danger that the District will
16 (again) socially transition her daughters without her knowledge and consent pursuant to the
17 Parental Secrecy Policy.

18 **CAUSES OF ACTION**

19 **COUNT ONE**

20 **42 U.S.C. § 1983—Substantive Due Process**

21 **(Facial Challenge to Parental Secrecy Policy)**

22 99. Ms. Regino hereby incorporates by reference all other paragraphs of this First
23 Amended Complaint as though fully set forth herein.

24 100. The Due Process Clause of the Fourteenth Amendment to the United States
25 Constitution protects the fundamental rights of parents⁴ to direct and control the upbringing of
26

27
28 ⁴ All references to “parents” herein are meant to indicate custodial parents. The term also includes
the concept of guardians.

1 their children; to make decisions concerning the care, custody, and control of their children; to
2 direct and control the medical and psychological treatment of their children; to make important
3 decisions in the lives of their children; and to make private familial decisions regarding their
4 children without undue interference by the state. These fundamental rights are deeply rooted in
5 our nation's history and tradition and implicit in the concept of ordered liberty.

6 101. On its face, the Parental Secrecy Policy violated in the past—and threatens to
7 violate in the future—these rights in the following ways:

- 8 a. The Parental Secrecy Policy authorizes children to make mature, consequential,
9 private, and potentially life-altering decisions without parental knowledge or
10 consent by excluding parents from the decision-making process on these matters
11 based on nothing more than the child's say-so;
- 12 b. The Parental Secrecy Policy takes from parents and arrogates to District personnel
13 the authority to make these consequential, private, and potentially life-altering
14 decisions for their children by excluding parents from the decision-making process
15 and placing decision-making authority in District personnel based on nothing more
16 than the child's say-so;
- 17 c. The Parental Secrecy Policy takes from parents the authority to make these
18 consequential, private, and potentially life-altering decisions for their children by
19 excluding parents from the decision-making process and placing decision-making
20 authority in their children based on nothing more than the child's say-so;
- 21 d. The Parental Secrecy Policy interferes with parents' right to familial privacy and
22 integrity by injecting the District into the family bonds that tie parents to their
23 children;
- 24 e. The Parental Secrecy Policy assumes that parents are not fit parents, capable of
25 making decisions on behalf of their children, which both (1) violates the
26 constitutionally mandated presumptions of fitness and affection unless proven
27 otherwise and (2) impermissibly sows seeds of doubt in children's mind about
28

whether their parents are acting in their best interests, thus creating a rift in the parent-child relationship;

f. 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 social transitioning, and assigns that responsibility to the child;

g. 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 social transitioning, and assigns that responsibility to the District;

h. 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;

i. 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;

j. The Parental Secrecy Policy results in the District providing psychological treatment to children, some of whom do not need it, without parents' knowledge or consent;

k. The Parental Secrecy Policy is harmful to children because it causes persistence of transgender identities that would otherwise naturally desist;

l. 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 necessary for their diagnosis, assessment, and treatment;

m. 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;

n. 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;

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

p. 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.

102. On its face, the Parental Secrecy Policy is not narrowly tailored to any compelling governmental purpose; does not further any important or legitimate government purpose; is not supported by any rational basis; constitutes an unwarranted interference with family relationships; and is the product of deliberate indifference to the rights of parents and their children.

103. Students have no right of privacy vis-à-vis their parents with respect to either their gender identity or the fact that their school is socially transitioning them. Further, even if such a

1 right existed in the abstract, based on the fact the District is socially transitioning students
2 transitioned throughout the school environment pursuant to the Parental Secrecy Policy, students
3 have no reasonable expectation of privacy vis-à-vis their parents with respect to their gender
4 identity or the fact that their school is socially transitioning them. In any event, parents' right to
5 notice and consent trumps any countervailing right students might have.

6 104. In the alternative, if parental *notice and consent* are not required, the Parental
7 Secrecy Policy is facially unconstitutional because it fails to require the District to at least *notify*
8 parents prior to socially transitioning their children.

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

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

15 **COUNT TWO**

16 **42 U.S.C. § 1983—Substantive Due Process**

17 **(As-Applied Challenge to Parental Secrecy Policy)**

18 107. Ms. Regino hereby incorporates by reference all other paragraphs of this First
19 Amended Complaint as though fully set forth herein.

20 108. As applied, the Parental Secrecy Policy violated in the past—and threatens to
21 violate in the future—Ms. Regino's fundamental right to direct and control the upbringing of her
22 children; to make decisions concerning the care, custody, and control of her children; to direct
23 and control the medical and psychological treatment of her children; to make important decisions
24 in the lives of her children; and to make private familial decisions regarding her children without
25 undue interference by the state in the following ways:

- 26 a. The Parental Secrecy Policy authorizes A.S. and C.S. to make mature,
27 consequential, private, and potentially life-altering decisions without parental
28

1 knowledge or consent by excluding their mother from the decision-making process
2 on these matters based on nothing more than their say-so;

3 b. The Parental Secrecy Policy takes from Ms. Regino and arrogates to District
4 personnel the authority to make these consequential, private, and potentially life-
5 altering decisions for A.S. and C.S. by excluding her from the decision-making
6 process and placing decision-making authority in District personnel based on
7 nothing more than their say-so;

8 c. The Parental Secrecy Policy takes from Ms. Regino the authority to make these
9 consequential, private, and potentially life-altering decisions for A.S. and C.S. by
10 excluding her from the decision-making process and placing decision-making
11 authority in her children based on nothing more than their say-so;

12 d. The Parental Secrecy Policy interferes with Ms. Regino's right to familial privacy
13 and integrity by injecting the District into the family bonds that tie her to her
14 children;

15 e. The Parental Secrecy Policy assumes that Ms. Regino is not a fit parent, capable
16 of making decisions on behalf of A.S. and C.S., which both (1) violates the
17 constitutionally mandated presumptions of fitness and affection unless proven
18 otherwise and (2) impermissibly sows seeds of doubt in her children's mind about
19 whether she is acting in their best interests, thus creating a rift in the parent-child
20 relationship;

21 f. The Parental Secrecy Policy usurps Ms. Regino's responsibility as the ultimate
22 decision-maker regarding A.S.'s and C.S.'s mental health and well-being,
23 including but not limited to decisions related to their gender identity and social
24 transitioning, and assigns that responsibility to A.S. and C.S.;

25 g. The Parental Secrecy Policy usurps Ms. Regino's responsibility as the ultimate
26 decision-maker regarding A.S.'s and C.S.'s mental health and well-being,
27 including but not limited to decisions related to their gender identity and social
28 transitioning, and assigns that responsibility to the District;

- 1 h. The Parental Secrecy Policy conceals important information from Ms. Regino
2 about her children’s mental health and well-being, thus precluding her from taking
3 actions that she would deem in her children’s best interests if she were provided
4 with the relevant information;
- 5 i. The Parental Secrecy Policy authorizes the District to engage in significant
6 psychological treatment of A.S. and C.S., in the form of socially transitioning them
7 to a new gender, without Ms. Regino’s knowledge or consent;
- 8 j. The Parental Secrecy Policy results in the District providing psychological
9 treatment to A.S. and C.S., whether or not they may need it, without Ms. Regino’s
10 knowledge or consent;
- 11 k. The Parental Secrecy Policy is harmful to A.S. and C.S. because it causes
12 persistence of transgender identities that would otherwise naturally desist;
- 13 l. The Parental Secrecy Policy results in the District providing substandard
14 psychological treatment of A.S. and C.S. because Ms. Regino’s involvement—and
15 her deep knowledge of her children over their life course, family interactions, and
16 extra-circular environment—is necessary for their diagnosis, assessment, and
17 treatment;
- 18 m. The Parental Secrecy Policy results in the District providing substandard
19 psychological treatment of A.S. and C.S. because it assumes that immediate and
20 unqualified affirmation is the only permissible response to a child exhibiting
21 gender confusion whereas, in reality, such a “one size fits all” approach to these
22 issues is a blunt instrument that fails to account for the unique facts involved in
23 each situation;
- 24 n. The Parental Secrecy Policy results in the District providing substandard
25 psychological treatment A.S. and C.S. because District personnel are not trained
26 mental health practitioners in the field and thus are not qualified to provide
27 students expressing gender confusion the care they need;
- 28

1 o. The Parental Secrecy Policy results in the District providing substandard
2 psychological treatment of A.S. and C.S. because creating a situation where a child
3 inhabits different gender identities and roles at home and school is inherently
4 psychologically unhealthy; and

5 p. The Parental Secrecy Policy results in the District providing unconsented-to
6 psychological treatment to A.S. and C.S. because: (1) they are cognitively
7 incapable of giving informed consent to life-altering psychological interventions
8 like social transitioning and the more-drastic gender-affirming care that is likely
9 to follow; (2) District personnel do not have sufficient knowledge of the
10 complexities and risks inherent in the field to provide A.S. and C.S. sufficient
11 information that they could provide informed consent even if they were
12 cognitively capable of doing so; and (3) District personnel do not have sufficient
13 knowledge of the complexities and risks inherent in the field to themselves
14 evaluate whether social transitioning is appropriate and ethical treatment for A.S.
15 and C.S.

16 109. Application of the Parental Secrecy Policy against Ms. Regino is not narrowly
17 tailored to any compelling governmental purpose; does not further any important or legitimate
18 government purpose; is not supported by any rational basis; constitutes an unwarranted
19 interference with Ms. Regino's family relationships; and is the product of deliberate indifference
20 to the rights of Ms. Regino and her children.

21 110. A.S. and C.S. have no right of privacy vis-à-vis their mother with respect to either
22 their gender identity or the fact that their school is socially transitioning them. Further, even if
23 they had such a right in the abstract, based on the fact that the District would socially transition
24 A.S. and C.S. throughout the school environment pursuant to the Parental Secrecy Policy, they
25 have no reasonable expectation of privacy vis-à-vis their mother with respect to either their gender
26 identity or the fact that their school is socially transitioning them. In any event, Ms. Regino's right
27 to notice and consent trumps any countervailing right A.S. and C.S. might have.

28 111. In the alternative, if parental *notice and consent* are not required, the Parental

1 Secrecy Policy is unconstitutional as applied to Ms. Regino because it fails to require the District
2 to at least *notify* her prior to socially transitioning her children.

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

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

9 **COUNT THREE**

10 **42 U.S.C. § 1983—Procedural Due Process**

11 **(Facial Challenge to Parental Secrecy Policy)**

12 114. Ms. Regino hereby incorporates by reference all other paragraphs of this First
13 Amended Complaint as though fully set forth herein.

14 115. The Due Process Clause of the Fourteenth Amendment to the United States
15 Constitution protects individuals' liberty interests against governmental infringement without due
16 process of law.

17 116. On its face, the Parental Secrecy Policy infringes upon Ms. Regino's protected
18 liberty interests without providing adequate procedural safeguards, including a thorough
19 investigation into the relevant facts, notice, and an opportunity to be heard.

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

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

26 **COUNT FOUR**

27 **42 U.S.C. § 1983—Procedural Due Process**

28 **(As-Applied Challenge to Parental Secrecy Policy)**

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

120. As applied, the Parental Secrecy Policy infringes upon Ms. Regino's protected liberty interests without providing adequate procedural safeguards, including a thorough investigation into the relevant facts, notice, and an opportunity to be heard.

121. 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.

122. 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 FIVE

42 U.S.C. § 1983—First Amendment

(Facial Challenge to Parental Secrecy Policy)

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

124. The First Amendment to the United States Constitution protects the fundamental right of individuals to enter into and maintain certain intimate human relationships, including family relationships, without undue interference by the state. This right includes the right of parents to form personal bonds with their children. Parents' relationships with their children have played a critical role in the culture and traditions of our Nation through the cultivation and transmittal of shared ideals and beliefs, thereby fostering diversity and acting as a buffer between the individual and the power of the state.

125. Parents’ relationships with their children are shaped by whether the child is a boy or a girl, and the nature and character of the personal bonds formed by those relationships will fundamentally differ based on whether the child is the parents’ “son” or “daughter.”

126. By authorizing the District to socially transition children without notifying parents and obtaining their consent based on nothing more than the child's preference that their parents

1 not be involved, the Parental Secrecy Policy intentionally interferes, on its face, with the intimate
2 associations that bond parent and child together because socially transitioning children to a
3 different gender has the effect of fundamentally altering the nature of the parent-child
4 relationship.

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

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

11 **COUNT SIX**

12 **42 U.S.C. § 1983—First Amendment**

13 **(As-Applied Challenge to Parental Secrecy Policy)**

14 129. Ms. Regino hereby incorporates by reference all other paragraphs of this First
15 Amended Complaint as though fully set forth herein.

16 130. Ms. Regino's relationships with A.S. and C.S. are shaped by the fact that her
17 daughters are girls, not boys, and the nature and character of the personal bonds formed by those
18 relationships would differ if her daughters were to become her sons.

19 131. By authorizing the District to socially transition A.S. and C.S. without notifying
20 her and obtaining her consent based on nothing more than their preference that she not be
21 involved, the Parental Secrecy Policy intentionally interferes, as applied, with the intimate
22 associations that bond her to her daughters.

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

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

PRAYER FOR RELIEF

WHEREFORE, Ms. Regino requests the following relief:

1. A declaration that the Parental Secrecy Policy is facially invalid and invalid as applied to her under the substantive and procedural components of the Due Process Clause and the First Amendment;
2. A permanent injunction preventing Defendants and all those acting in concert with them from implementing, enforcing, or abiding by the Parental Secrecy Policy or any policy that allows Defendants to socially transition minor children without parental notification and consent at all times in the future, both facially and as applied to her;
3. In the alternative, a permanent injunction preventing Defendants and all those acting in concert with them from implementing, enforcing, or abiding by the Parental Secrecy Policy or any policy that allows Defendants to socially transition children without prior parental notification at all times in the future, both facially and as applied to her;
4. Costs and attorney's fees pursuant to 42 U.S.C. § 1988;
5. A trial by jury on all claims for which she has such a right; and
6. Such further relief that the Court deems just and proper.

Respectfully submitted,

Dated: April 10, 2023

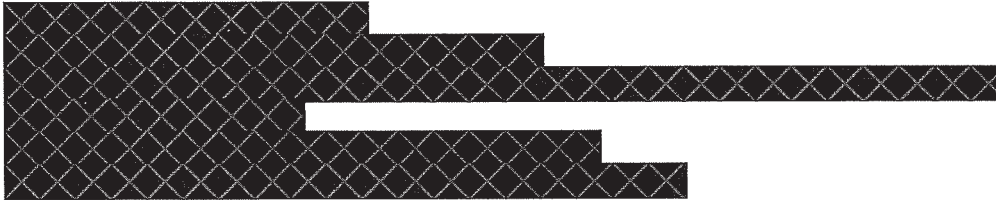
**DHILLON LAW GROUP INC.
CENTER FOR AMERICAN LIBERTY**

/s/ Harmeet K. Dhillon

HARMEET K. DHILLON
MICHAEL A. COLUMBO
JOSHUA W. DIXON
ERIC A. SELL

Attorneys for Plaintiff
AURORA REGINO

EXHIBIT A



From: Chico Unified School District via Aeries Communications <donotreply@parentsquare.com>
To: [REDACTED]
Sent: Friday, January 13, 2023 at 06:24:35 PM PST
Subject: A Message From the CUSD Superintendent



Chico Unified School District

Chico Unified School District posted in Chico Unified School District

A Message From the CUSD Superintendent

Dear Chico Unified Families,

Yesterday (1/12/23) an article was published online and is making news headlines. At 4:07 p.m. today (1/13/23) we received the legal paperwork that sparked the initial news story. While our legal counsel is currently reviewing the lawsuit, we can address the article's headline and assure our community that Chico Unified *does not* have a "Parental Secrecy Policy", nor do we ever try to change a student's individual identity.

In regard to the lawsuit, we value our community and will thoroughly review and investigate any claims. As you know, Chico Unified continues to focus on family engagement and works hard to maintain open and transparent communication. We highly value the relationships our families have built with their schools. Through the challenges

faced by our community over the past few years, from the Camp Fire to the Pandemic, we heard the needs shared by our students and families and worked to put appropriate student supports in place. We have increased staffing including counselors, reading teachers, and the opportunity for high school students to take increased courses. We take pride in the hard work performed daily at our schools to provide a high-quality educational experience for our students.

While we cannot discuss legal proceedings, we do encourage our families to reach out to our District Office if they have specific questions regarding our curriculum, instruction or policies.

Sincerely, Kelly Staley

Kelly Staley, Superintendent
Chico Unified School District
1163 East 7th Street
Chico, CA 95928
Office: 530-891-3000 x 20235
[*kstaley@chicousd.org*](mailto:kstaley@chicousd.org)

View in Aeries Communications

Please do not reply to this email.

Stay involved with your child's learning and activities at school.



You received this email because you are a Aeries Communications user in Chico Unified School District. If you received this email in error or wish to disable your account, [click here to unsubscribe](#).

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EXHIBIT B

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 Academy for Change (AFC - Community Day) 4000 Highway 99, Suite 100 Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Bidwell Junior High School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Center For Alternative Learning (CAL) 4000 Highway 99, Suite 100 Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Chapman Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Chico High School 4000 Highway 99, Suite 100 Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Chico Junior High School 4000 Highway 99, Suite 100 Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Chico Unified School District 4000 Highway 99, Suite 100 Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Citrus Elementary 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Emma Wilson Elementary 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Fair View High School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Hooker Oak Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Little Chico Creek Elementary 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Loma Vista (Special Services Program)** 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Marigold School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Marsh Junior High School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 McManus Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Neal Dow Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Oak Bridge Academy (Online Learning) 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Oakdale (Independent Study) 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Parkview Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Pleasant Valley High School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Roseville Elementary 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE
 Shasta Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE	 Sierra View Elementary School 1000 Bidwell Ave Chico, CA 95926 SCHOOL INFO CONTACT US VISIT WEBSITE

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EXHIBIT C



Chico Unified
School District



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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.

Quick Links

Chico Unified School District
(530) 891-3000

- [LCAP](#)
- [SARC Reports](#)

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.

[Our District](#) | [Schools](#) | [Programs](#) | [Serving You](#) | [News](#) | [Contact US](#)

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



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



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Kelly Staley,
Superintendent
kstaley@chicousd.org

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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 x20149 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.

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



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**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 1 of 7

Nondiscrimination/Harassment

The district designates the individual(s) identified below as the employee(s) responsible for coordinating the district's efforts to comply with applicable state and federal civil rights laws, and to answer inquiries regarding the district's nondiscrimination policies. The individual(s) shall also serve as the compliance officer(s) specified in AR 1312.3 - Uniform Complaint Procedures as the responsible employee to handle complaints alleging unlawful discrimination targeting a student, including discriminatory harassment, intimidation, or bullying, based on the student's actual or perceived race, color, ancestry, nationality, national origin, immigration status, ethnic group identification, ethnicity, age, religion, marital status, pregnancy, parental status, physical or mental disability, medical condition, sex, sexual orientation, gender, gender identity, gender expression, genetic information, or any other legally protected status or association with a person or group with one or more of these actual or perceived characteristics.. The coordinator/compliance officer(s) may be contacted at: (Education Code 234.1; 5 CCR 4621)

Kristine Keene
Director of State and Federal Programs
1163 East Seventh St.
Chico, CA 95928
(530) 891-3000

(cf. 1312.1 - Complaints Concerning District Employees)
(cf. 1312.3 - Uniform Complaint Procedures)
(cf. 5145.7 - Sexual Harassment)
(cf. 5145.71 - Title IX Sexual Harassment Complaint Procedures)

Measures to Prevent Discrimination

To prevent unlawful discrimination, including discriminatory harassment, intimidation, retaliation, and bullying, of students at district schools or in school activities and to ensure equal access of all students to the educational program, the Superintendent or designee shall implement the following measures:

1. Publicize the district's nondiscrimination policy and related complaint procedures, including the coordinator/compliance officer's contact information, to students, parents/guardians, employees, volunteers, and the general public by posting them in prominent locations and providing easy access to them through district-supported communications.
2. Post the district's policies and procedures prohibiting discrimination, harassment, student sexual harassment, intimidation, bullying, and cyberbullying, including a section on social media bullying that includes all of the references described in Education Code 234.6 as possible forums for social media, in a prominent location on the district's web site in a manner that is easily accessible to parents/guardians and students (Education Code 234.6)

(cf. 0410 - Nondiscrimination in District Programs and Activities)
(cf. 1113 - District and School Web Sites)
(cf. 1114 - District-Sponsored Social Media)
(cf. 5131.2 - Bullying)
(cf. 5145.9 - Hate-Motivated Behavior)

3. Post the definition of sex discrimination and harassment as described in Education Code 230, including the rights set forth in Education Code 221.8, in a prominent location on the district's web site in a manner

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Chico Unified School District

1163 East Seventh Street, Chico, CA 95928-5999
(530) 891-3000

**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 2 of 7

that is easily accessible to parents/guardians and students (Education Code 234.6)

4. Post in a prominent location on the district web site in a manner that is easily accessible to parents/guardians and students information regarding Title IX prohibitions against discrimination based on a student's sex, gender, gender identity, pregnancy, and parental status, including the following: (Education Code 221.6, 221.61, 234.6)
 - a. The name and contact information of the district's Title IX coordinator, including the phone number and email address
 - b. The rights of students and the public and the responsibilities of the district under Title IX, including a list of rights as specified in Education Code 221.8 and web links to information about those rights and responsibilities located on the web sites of the Office for Equal Opportunity and the U.S. Department of Education's Office for Civil Rights (OCR)
 - c. A description of how to file a complaint of noncompliance with Title IX, which shall include:
 - (1) An explanation of the statute of limitations within which a complaint must be filed after an alleged incident of discrimination has occurred and how a complaint may be filed beyond the statute of limitations
 - (2) An explanation of how the complaint will be investigated and how the complainant may further pursue the complaint, including web links to this information on the OCR's web site
 - (3) A web link to the OCR complaints form and the contact information for the office, including the phone number and email address for the office
5. Post a link to statewide CDE-compiled resources, including community-based organizations, that provide support to youth who have been subjected to school-based discrimination, harassment, intimidation, or bullying and to their families. Such resources shall be posted in a prominent location on the district's web site in a manner that is easily accessible to parents/guardians and students. (Education Code 234.5, 234.6)
6. Provide to students a handbook that contains age-appropriate information that clearly describes the district's nondiscrimination policy, procedures for filing a complaint, and resources available to students who feel that they have been the victim of any such behavior.
7. Annually notify all students and parents/guardians of the district's nondiscrimination policy, including its responsibility to provide a safe, nondiscriminatory school environment for all students, including transgender and gender-nonconforming students. The notice shall inform students and parents/guardians that they may request to meet with the compliance officer to determine how best to accommodate or resolve concerns that may arise from the district's implementation of its nondiscrimination policies. The notice shall also inform all students and parents/guardians that, to the extent possible, the district will address any individual student's interests and concerns in private.

(cf. 5145.6 - Parental Notifications)

8. Ensure that students and parents/guardians, including those with limited English proficiency, are notified of how to access the relevant information provided in the district's nondiscrimination policy and related



Chico Unified School District

1163 East Seventh Street, Chico, CA 95928-5999
(530) 891-3000

**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 3 of 7

complaint procedures, notices, and forms in a language they can understand.

If 15 percent or more of students enrolled in a particular district school speak a single primary language other than English, the district's policy, regulation, forms, and notices concerning nondiscrimination shall be translated into that language in accordance with Education Code 234.1 and 48985. In all other instances, the district shall ensure meaningful access to all relevant information for parents/guardians with limited English proficiency.

9. Provide to students, employees, volunteers, and parents/guardians age appropriate training and/or information regarding the district's nondiscrimination policy; what constitutes prohibited discrimination, including discriminatory harassment, intimidation, retaliation, or bullying; how and to whom a report of an incident should be made; and how to guard against segregating or stereotyping students when providing instruction, guidance, supervision, or other services to them. Such training and information shall include details of guidelines the district may use to provide a discrimination-free environment for all district students, including transgender and gender-nonconforming students.

(cf. 1240 – Volunteer Assistance)

(cf. 4131 - Staff Development)

(cf. 4231 - Staff Development)

(cf. 4331 - Staff Development)

10. At the beginning of each school year, inform school employees that any employee who witnesses any act of unlawful discrimination, including discriminatory harassment, intimidation, or bullying against a student is required to intervene if it is safe to do so. (Education Code 234.1)

(cf. 4112.9/4212.9/4312.9 - Employee Notifications)

11. At the beginning of each school year, inform each principal or designee of the district's responsibility to provide appropriate assistance or resources to protect students from threatened or potentially discriminatory behavior and ensure their privacy rights.

Enforcement of District Policy

The Superintendent or designee shall take appropriate actions to reinforce BP 5145.3 – Nondiscrimination/Harassment. As needed, these actions may include any of the following:

1. Removing vulgar or offending graffiti

(cf. 5131.5 - Vandalism and Graffiti)

2. Providing training to students, staff, and parents/guardians about how to recognize unlawful discrimination, and how to report it or file a complaint, and how to respond
3. Disseminating and/or summarizing the district's policy and regulation regarding unlawful discrimination
4. Consistent with the laws regarding the confidentiality of student and personnel records, communicating to students, parents/guardians, and the community the school's response plan to unlawful discrimination or harassment

(cf. 4112.6/4212.6/4312.6 - Personnel Files)

(cf. 4119.23/4219.23/4319.23 - Unauthorized Release of Confidential/Privileged Information)

(cf. 5125 - Student Records)

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Chico Unified School District

1163 East Seventh Street, Chico, CA 95928-5999
(530) 891-3000

**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 4 of 7

5. Taking appropriate disciplinary action against students, employees, and anyone determined to have engaged in wrongdoing in violation of district policy, including any student who is found to have filed a complaint of discrimination that the student knew was not true

(cf. 4118 – Dismissal/Suspension/Disciplinary Action)

(cf. 4218 - Dismissal/Suspension/Disciplinary Action)

(cf. 5144 - Discipline)

(cf. 5144.1 - Suspension and Expulsion/Due Process)

(cf. 5144.2 - Suspension and Expulsion/Due Process (Students with Disabilities))

(cf. 6159.4 - Behavioral Interventions for Special Education Students)

Process for Initiating and Responding to Complaints

Students who feel that they have been subjected to unlawful discrimination described above or in district policy is strongly encouraged to immediately contact the Compliance Officer, principal, or any other staff member. In addition, students who observe any such incident are strongly encouraged to report the incident to the Compliance Officer or principal, whether or not the alleged victim files a complaint.

Any school employee who observes an incident of unlawful discrimination, including discriminatory harassment, intimidation, retaliation, or bullying, or to whom such an incident is reported shall report the incident to the Compliance Officer or principal within a school day, whether or not the alleged victim files a complaint.

Any school employee who witnesses an incident of unlawful discrimination, including discriminatory harassment, intimidation, retaliation, or bullying, shall immediately intervene to stop the incident when it is safe to do so. (Education Code 234.1)

When a report of unlawful discrimination, including discriminatory harassment, intimidation, retaliation, or bullying, is made to or received by the principal or compliance officer, the principal or compliance officer shall notify the student or parent/guardian of the right to file a formal complaint in accordance with AR 1312.3 - Uniform Complaint Procedures or, for complaints of sexual harassment that meet the federal Title IX definition, AR 5145.71 - Title IX Sexual Harassment Complaint Procedures. Once notified verbally or in writing, the compliance officer shall begin the investigation and shall implement immediate measures necessary to stop the discrimination and ensure that all students have access to the educational program and a safe school environment. Any interim measures adopted to address unlawful discrimination shall, to the extent possible, not disadvantage the complainant or a student who is the victim of the alleged unlawful discrimination.

Any report or complaint alleging unlawful discrimination by the principal, compliance officer, or any other person to whom a report would ordinarily be made or complaint filed shall instead be made to or filed with the Superintendent or designee who shall determine how the complaint will be investigated.

(cf. 5141.4 - Child Abuse Prevention and Reporting)

Transgender and Gender-Nonconforming Students

Gender identity of a student means the student's gender-related identity, appearance, or behavior, as determined from the student's internal sense, whether or not that gender-related identity, appearance, or behavior is different from that traditionally associated with the student's physiology or assigned sex at birth.

Gender expression means a student's gender-related appearance and behavior, whether stereotypically associated with the student's assigned sex at birth. (Education Code 210.7)

Gender transition refers to the process in which a student changes from living and identifying as the sex Regulation Approved: 06/15; 09/30/15; 01/17/17; 02/12/18; 02/25/19; 11/18/19; 03/01/21



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**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 5 of 7

assigned to the student at birth to living and identifying as the sex that corresponds to the student's gender identity.

Gender-nonconforming student means a student whose gender expression differs from stereotypical expectations.

Transgender student means a student whose gender identity is different from the gender assigned at birth.

The district prohibits acts of verbal, nonverbal, or physical aggression, intimidation, or hostility that are based on sex, gender identity, or gender expression, or that have the purpose or effect of producing a negative impact on the student's academic performance or of creating an intimidating, hostile, or offensive educational environment, regardless of whether the acts are sexual in nature. Examples of the types of conduct which are prohibited in the district and which may constitute gender-based harassment include, but are not limited to:

1. Refusing to address a student by a name and the pronouns consistent with the student's gender identity
2. Disciplining or disparaging a student or excluding the student from participating in activities, for behavior or appearance that is consistent with his/her gender identity or that does not conform to stereotypical notions of masculinity or femininity, as applicable
3. Blocking a student's entry to the restroom that corresponds to the student's gender identity
4. Taunting a student because the student participates in an athletic activity more typically favored by a student of the other sex
5. Revealing a student's transgender status to individuals who do not have a legitimate need for the information, without the student's consent
6. Use of gender-specific slurs
7. Physical assault of a student motivated by hostility toward the student because of the student's gender, gender identity, or gender expression

The district's uniform complaint procedures (AR 1312.3) or Title IX sexual harassment procedures (AR 5145.71), as applicable, shall be used to report and resolve complaints alleging discrimination against transgender and gender-nonconforming students.

Examples of bases for complaints include, but are not limited to, the above list, as well as improper rejection by the district of a student's asserted gender identity, denial of access to facilities that correspond with a student's gender identity, improper disclosure of a student's transgender status, discriminatory enforcement of a dress code, and other instances of gender-based harassment.

To ensure that transgender and gender-nonconforming students are afforded the same rights, benefits, and protections provided to all students by law and Board policy, the district shall address each situation on a case-by-case basis, in accordance with the following guidelines:

1. Right to privacy: A student's transgender or gender-nonconforming status is the student's private information and the district shall only disclose the information to others with the student's prior written consent, except when the disclosure is otherwise required by law or when the district has compelling



Chico Unified School District

1163 East Seventh Street, Chico, CA 95928-5999
(530) 891-3000

**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 6 of 7

evidence that disclosure is necessary to preserve the student's physical or mental well-being. In any case, the district shall only allow disclosure of a student's personally identifiable information to employees with a legitimate educational interest as determined by the district pursuant to 34 CFR 99.31. Any district employee to whom a student's transgender or gender-nonconforming status is disclosed shall keep the student's information confidential. When disclosure of a student's gender identity is made to a district employee by a student, the employee shall seek the student's permission to notify the compliance officer. If the student refuses to give permission, the employee shall keep the student's information confidential, unless the employee is required to disclose or report the student's information pursuant to this administrative regulation, and shall inform the student that honoring the student's request may limit the district's ability to meet the student's needs related to the student's status as a transgender or gender-nonconforming student. If the student permits the employee to notify the compliance officer, the employee shall do so within three school days.

As appropriate given the student's need for support, the compliance officer may discuss with the student any need to disclose the student's transgender or gender-nonconformity status or gender identity or gender expression to the student's parents/guardians and/or others, including other students, teacher(s), or other adults on campus. The district shall offer support services, such as counseling, to students who wish to inform their parents/guardians of their status and desire assistance in doing so.

(cf. 1340 - Access to District Records)
(cf. 3580 - District Records)

2. **Determining a Student's Gender Identity:** The Compliance Officer shall accept the student's assertion of his/her gender identity and begin to treat the student consistent with that gender identity unless district personnel present a credible and supportable basis for believing that the student's assertion is for an improper purpose.
3. **Addressing a Student's Transition Needs:** The Compliance Officer shall arrange a meeting with the student and, if appropriate, the student's parents/guardians to identify and develop strategies for ensuring that the student's access to educational programs and activities is maintained. The meeting shall discuss the transgender or gender-nonconforming student's rights and how those rights may affect and be affected by the rights of other students and shall address specific subjects related to the student's access to facilities and to academic or educational support programs, services, or activities, including, but not limited to, sports and other competitive endeavors. In addition, the Compliance Officer shall identify specific school site employee(s) to whom the student may report any problem related to the student's status as a transgender or gender-nonconforming individual, so that prompt action could be taken to address it. Alternatively, if appropriate and desired by the student, the school may form a support team for the student that will meet periodically to assess whether the arrangements for the student are meeting the student's educational needs and providing equal access to programs and activities, educate appropriate staff about the student's transition, and serve as a resource to the student to better protect the student from gender-based discrimination.
4. **Accessibility to Sex-Segregated Facilities, Programs, and Activities:** When the district maintains sex-segregated facilities, such as restrooms and locker rooms, or offers sex-segregated programs and activities, such as physical education classes, intermural sports, and interscholastic athletic programs, students shall be permitted to access facilities and participate in programs and activities consistent with their gender identity. To address any student's privacy concerns in using sex-segregated facilities, the district shall offer available options such as a gender-neutral or single-use restroom or changing area, a bathroom stall with a door, an area in the locker room separated by a curtain or screen, access to a



Chico Unified School District

1163 East Seventh Street, Chico, CA 95928-5999
(530) 891-3000

**Administrative
Regulation:**

#5145.3

Section: 5000

Students

Page 7 of 7

staff member's office, or use of the locker room before or after the other students. However, the district shall not require a student to utilize these options because the student is transgender or gender-nonconforming. In addition, a student shall be permitted to participate in accordance with the student's gender identity in other circumstances where students are separated by gender, such as for class discussions, yearbook pictures, and field trips. A student's right to participate in a sex-segregated activity in accordance with the student's gender identity shall not render invalid or inapplicable any other eligibility rule established for participation in the activity.

(cf. 6145 - Extracurricular and Cocurricular Activities)

(cf. 6145.2 - Athletic Competition)

(cf. 6153 - School-Sponsored Trips)

(cf. 7110 - Facilities Master Plan)

5. Student Records: A student's legal name or gender as entered on the mandatory student record required pursuant to 5 CCR 432 shall only be changed with proper documentation. When a student presents government-issued documentation of a name and/or gender change or submits a request for a name and/or gender change through the process specified in Education Code 49070, the district shall update the student's records. (Education Code 49062.5, 49070)

(cf. 5125 - Student Records)

(cf. 5125.1 - Release of Directory Information)

(cf. 5125.3 - Challenging Student Records)

6. Names and Pronouns: If a student so chooses, district personnel shall be required to address the student by a name and the pronoun(s) consistent with the student's gender identity, without the necessity of a court order or a change to the student's official district record. However, inadvertent slips or honest mistakes by district personnel in the use of the student's name and/or consistent pronouns will, in general, not constitute a violation of this administrative regulation or the accompanying district policy.

7. Uniforms/Dress Code: A student has the right to dress in a manner consistent with the student's gender identity, subject to any dress code adopted on a school site.

(cf. 5132 - Dress Code)

EXHIBIT G

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AURORA REGINO

**IN THE 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: 2:23-cv-00032-JAM-DMC

PROOF OF SERVICE

1 I, Harmeet K. Dhillon, hereby certify that on April 10, 2023, I electronically filed the above
2 documents with the Clerk of the Court using CM/ECF, which will send electronic notification of
3 such filing to all registered counsel.

4 By: /s/ Harmeet K. Dhillon
5 Harmeet K. Dhillon

6 Date: April 10, 2023
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EXHIBIT A

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**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

I. CREDENTIALS & SUMMARY	1
II. BACKGROUND ON THE FIELD.....	9
A. The biological baseline of the binary sexes	9
B. Definition and diagnosis of gender dysphoria	14
C. Impact of gender dysphoria on minority and vulnerable groups	16
D. Three competing conceptual models of gender dysphoria and transgender identity.....	17
E. Four competing models of therapy	21
III. THERE IS NO CONSENSUS OR AGREED “STANDARD OF CARE” CONCERNING THERAPEUTIC APPROACHES TO CHILD OR ADOLESCENT GENDER DYSPHORIA.	29
A. Experts and organizations disagree as to whether “distress” is a necessary element for diagnoses that justifies treatment for gender identity issues.	30
B. Opinions and practices vary widely about the utilization of social transition for children and adolescents.....	32
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.	33
D. Internationally, there has been a recent marked trend against the use of puberty blockers and cross-sex hormones.	36
E. Opinions and practices vary widely with respect to the administration of puberty blockers and cross-sex hormones.	38
IV. GENDER IDENTITY IS EMPIRICALLY NOT FIXED FOR MANY INDIVIDUALS.....	41
A. Transgender identity has not been shown to be biologically based, and its epidemiology demonstrates large and radical changes across time and geography.	41
B. Most children who experience gender dysphoria ultimately “desist” and achieve comfort with their biological sex.	45
C. Desistance is increasingly observed among teens and young adults who first manifest GD during or after adolescence.	47

V. TRANSITION AND AFFIRMATION IS AN IMPORTANT PSYCHOLOGICAL AND MEDICAL INTERVENTION THAT CHANGES GENDER IDENTITY OUTCOMES.....	52
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.....	52
B. Social transition of young children is a powerful psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance.	53
C. Administration of puberty blockers is a powerful medical and psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance on the historically observed timeline.	56
VI. TRANSITION AND AFFIRMATION ARE EXPERIMENTAL THERAPIES THAT HAVE NOT BEEN SHOWN TO IMPROVE MENTAL OR PHYSICAL HEALTH OUTCOMES BY YOUNG ADULTHOOD.....	57
A. The knowledge base concerning therapies for gender dysphoria is “very low quality.”	58
B. Youth who adopt a transgender identity show no durable improvement in mental health after social, hormonal, or surgical transition and affirmation.	62
C. Long-term mental health outcomes for individuals who persist in a transgender identity are poor.....	64
VII. TRANSITION AND AFFIRMATION DO NOT DECREASE, AND MAY INCREASE, THE RISK OF SUICIDE.....	66
A. The risk of suicide among transgender youth is confused and exaggerated in the public mind.	66
B. Transition of any sort has not been shown to reduce levels of suicide.	69
C. Long-term life in a transgender identity correlates with very high rates of completed suicide among adults.	70
VIII. HORMONAL INTERVENTIONS ARE EXPERIMENTAL PROCEDURES THAT HAVE NOT BEEN PROVEN SAFE.....	74
A. Use of puberty blockers has not been shown to be safe or reversible for gender dysphoria.	75

B. Use of cross-sex hormones in adolescents for gender dysphoria has not been shown to be medically safe except in the short term..... 82

C. The timing of harms. 87

IX. PARENTAL INVOLVEMENT IS ESSENTIAL IN MOST CASES FOR ETHICAL TREATMENT OF A CHILD WHO SUFFERS FROM GENDER DYSPHORIA OR SEEKS SOCIAL TRANSITION..... 90

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..... 90

B. Parental involvement is necessary for accurate and thorough diagnosis of the child. 91

C. Parental involvement is important for effective psychotherapeutic treatment and support of the child..... 96

D. Schools are not equipped to enable and obtain informed consent, nor resolve the complex ethical implications raised by social transition. 97

Bibliography..... 104

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; Kozłowska 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 organization⁴— 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; Vandebussche 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 7¹¹; 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 et 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.” (Kozłowska 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 will 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 amnesic 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 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.

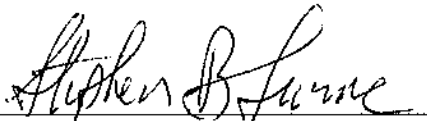
211. For this reason, it is my opinion that asking a child whether he or she wishes to transition to living as the opposite sex, or giving large weight to the child's expressed wishes by no means satisfies the MHP's ethical obligation to obtain informed consent before assisting that child to transition 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.
- Zucker, K. (2019). *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*. ARCHIVES OF SEXUAL BEHAVIOR 48(7) 1983–1992.
- Zucker, K. (2020). *Different strokes for different folks*. CHILD ADOLESCENT HEALTH 25(1): 36–37. <https://doi.org/10.1111/camh.12330>.

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) 1999-2002 Case 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 erythematosus 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 of 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 FSDD-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) Books

- 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 Sexualität: Glück und Erfüllung in der Liebe, Wilhelm Heyne Verlag, München, 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
- 57) Turner LA, Althof SE, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Treating erectile dysfunction with external vacuum devices: impact upon sexual, psychological, and marital functioning. *Journal of Urology* 1990;141(1):79-82
- 58) Risen CB, Althof SE. An essay on the diagnosis and nature of paraphilia *Journal of Sex & Marital Therapy* 1990; 16(2):89-102.
- 59) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Through the eyes of women: the sexual and psychological responses of women to their partners' treatment with self-injection or vacuum constriction therapy. *International Journal of Impotence Research (supplement 2)*1990;346-7.
- 60) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. A comparison of the effectiveness of two treatments for erectile dysfunction: self injection vs. external vacuum devices. . *International Journal of Impotence Research (supplement 2)*1990;289-90
- 61) Kursh E, Turner L, Bodner D, Althof S, Levine S. A prospective study on the use of the vacuum pump for the treatment of impotence. *International Journal of Impotence Research (supplement 2)*1990;340-1.
- 62) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of intracavernous therapy in the treatment of erectile dysfunction in *Journal of Sex & Marital Therapy* 1991; 17(2):101-112
- 63) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of vacuum pump devices in the treatment of erectile dysfunction in *Journal of Sex & Marital Therapy* 1991;17(2):81-93
- 64) Turner LA, Althof SE, Levine SB, Bodner DB, Kursh ED, Resnick MI. A 12-month comparison of the effectiveness of two treatments for erectile

- dysfunction: self injection vs. external vacuum devices. *Urology* 1992;39(2):139-44
- 65) Althof SE, The pathogenesis of psychogenic impotence. *J. Sex Education and Therapy*. 1991; 17(4):251-66
 - 66) Mehta P, Bedell WH, Cumming W, Bussing R, Warner R, Levine SB. Letter to the editor. Reflections on hemophilia camp. *Clinical Pediatrics* 1991; 30(4):259-260
 - 67) Successful Sexuality. Belonging/Hemophilia. (Caremark Therapeutic Services), Autumn, 1991
 - 68) Psychological intimacy. *Journal of Sex & Marital Therapy* 1991; 17(4):259-68
 - 69) Male sexual problems and the general physician, *Georgia State Medical Journal* 1992; 81(5): 211-6
 - 70) Althof SE, Turner LA, Levine SB, Bodner DB, Kursh E, Resnick MI. Through the eyes of women: The sexual and psychological responses of women to their partner's treatment with self-injection or vacuum constriction devices. *Journal of Urology* 1992; 147(4):1024-7
 - 71) Curry SL, Levine SB, Jones PK, Kurit DM. Medical and Psychosocial predictors of sexual outcome among women with systemic lupus erythematosus. *Arthritis Care and Research* 1993; 6:23-30
 - 72) Althof SE, Levine SB. Clinical approach to sexuality of patients with spinal cord injury. *Urological Clinics of North America* 1993; 20(3):527-34
 - 73) Gender-disturbed males. *Journal of Sex & Marital Therapy* 19(2):131-141, 1993
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- 31) Sex and Gender by M. Diamond and A.Yates Child Psychiatric Clinics of North America W. B. Saunders, Philadelphia, Pennsylvania, 2004, 268 pp in Archives of Sexual Behavior April 2007 on line publication in Dec.2006 at <http://dx.doi.org/10.1007/s10508-006-9114-7>
- 32) Getting Past the Affair: A program to help you cope, heal, and move on— together or apart by Douglas K. Snyder, Ph.D, Donald H. Baucom, Ph.D, and Kristina Coop Gordon, Ph.D, New York, Guilford Press, 2007 in Journal of Sex and Marital Therapy,34:1-3, 2007
- 33) Dancing with Science, Ideology and Technique. A review of Sexual Desire Disorders: A casebook Sandra R. Leiblum editor, Guilford Press, New York, 2010. In Journal of Sex Research 2011.
- 34) What is more bizarre: the transsexual or transsexual politics? A review of Men Trapped in Men’s Bodies: Narratives of Autogynephilic Transsexualism by Anne A. Lawrence, New York, Springer, 2014. In Sex Roles: a Journal of Research, 70, Issue 3 (2014), Page 158-160, 2014. DOI: 10.1007/s11199-013-0341-9
- 35) There Are Different Ways of Knowing. A review of: How Sexual Desire Works: The Enigmatic Urge by Frederick Toates, Cambridge, UK, Cambridge University Press, in Sexuality and Culture (2015) 19:407–409 DOI 10.1007/s12119-015-9279-0
- 36) The Dynamics of Infidelity: Applying Relationship Science to Clinical Practice by Lawrence Josephs, American Psychological Association, Washington, DC, 2018, pp. 287, \$69.95 in Journal of Sex and Marital Therapy10.1080/0092623X.2018.1466954, 2018. For free access: <https://www.tandfonline.com/eprint/UgiIHbWbpdedbsXWXpNf/full>
- 37) Transgender Mental Health by Eric Yarbrough, American Psychiatric Association Publications, 2018, Journal and Marital & Sexual Therapy, <https://doi.org/10.1080/0092623X.2018.1563345> .

- 38) Seduced into Darkness: Transcending My Psychiatrist's Sexual Abuse by Carrie T. Ishee, Terra Nova Books, Santa Fe, in Journal of Sex and Marital Therapy, in press 2020. 10.1080/0092623X2020.175847
- 39) Principles and Practices of Sex Therapy, 6th edition, (2020) KSK Hall, IM Binik (editors), Guilford Press, New York in Journal of Sex and Marital Therapy 47(4): May 2021. Doi 10.1080/0092623X2021.1920736

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>

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF Eastern District of California

**Form 1. Notice of Appeal from a Judgment or Order of a
United States District Court**

U.S. District Court case number: 2:23-cv-00032-JAM-DMC

Notice is hereby given that the appellant(s) listed below hereby appeal(s) to the United States Court of Appeals for the Ninth Circuit.

Date case was first filed in U.S. District Court: 1/06/2023

Date of judgment or order you are appealing: 7/11/2023

Docket entry number of judgment or order you are appealing: 57, 58

Fee paid for appeal? (*appeal fees are paid at the U.S. District Court*)

☒ Yes ☐ No ☐ IFP was granted by U.S. District Court

List all Appellants (*List each party filing the appeal. Do not use "et al." or other abbreviations.*)

Aurora Regino

Is this a cross-appeal? ☐ Yes ☒ No

If yes, what is the first appeal case number?

Was there a previous appeal in this case? ☐ Yes ☒ No

If yes, what is the prior appeal case number?

Your mailing address (if pro se):

City: State: Zip Code:

Prisoner Inmate or A Number (if applicable):

Signature /s/ Harmeen K. Dhillon

Date Jul 20, 2023

Complete and file with the attached representation statement in the U.S. District Court

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 6. Representation Statement

Instructions for this form: <http://www.ca9.uscourts.gov/forms/form06instructions.pdf>

Appellant(s) *(List each party filing the appeal, do not use "et al." or other abbreviations.)*

Name(s) of party/parties:

Aurora Regino

Name(s) of counsel (if any):

Harmeet K. Dhillon

Address: 177 Post St., Suite 700 San Francisco, CA 94108

Telephone number(s): (415) 433-1700

Email(s): harmeet@dhillonlaw.com

Is counsel registered for Electronic Filing in the 9th Circuit? ☒ Yes ☐ No

Appellee(s) *(List only the names of parties and counsel who will oppose you on appeal. List separately represented parties separately.)*

Name(s) of party/parties:

Kelly Staley

Name(s) of counsel (if any):

BRIAN A. DUUS,
JIMMIE E. JOHNSON

Address: 1390 Willow Pass Road, Suite 700 Concord, CA 94520-7913

Telephone number(s): (925) 974-8600

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To list additional parties and/or counsel, use next page.

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

Continued list of parties and counsel: *(attach additional pages as necessary)*

Appellants

Name(s) of party/parties:

Aurora Regino

Name(s) of counsel (if any):

Joshua W. Dixon

Address: 1311 South Main Street, Suite 207 Mount Airy, MD 2177

Telephone number(s): (703) 687-6200

Email(s): Jdixon@libertycenter.org

Is counsel registered for Electronic Filing in the 9th Circuit? ☒ Yes ☐ No

Appellees

Name(s) of party/parties:

Name(s) of counsel (if any):

Address:

Telephone number(s):

Email(s):

Name(s) of party/parties:

Name(s) of counsel (if any):

Address:

Telephone number(s):

Email(s):

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CIVIL, APPEAL, CLOSED

**U.S. District Court
Eastern District of California - Live System (Sacramento)
CIVIL DOCKET FOR CASE #: 2:23-cv-00032-JAM-DMC**

Regino v. Staley
Assigned to: Senior Judge John A. Mendez
Referred to: Magistrate Judge Dennis M. Cota
Case in other court: US Court of Appeals, 23-16031
Cause: 42:1981 Civil Rights

Date Filed: 01/06/2023
Date Terminated: 07/11/2023
Jury Demand: Plaintiff
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

Plaintiff

Aurora Regino

represented by **Harmeet Kaur Dhillon**
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LEAD ATTORNEY
ATTORNEY TO BE NOTICED

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ATTORNEY TO BE NOTICED

V.

Defendant

Kelly Staley
Superintendent

represented by **Brian A. Duus**
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ATTORNEY TO BE NOTICED

Defendant

Caitlin Dalby

TERMINATED: 04/12/2023

represented by **Brian A. Duus**
(See above for address)
TERMINATED: 04/12/2023
LEAD ATTORNEY

Jimmie E. Johnson , I
(See above for address)
TERMINATED: 04/12/2023

Louis Anthony Leone
(See above for address)
TERMINATED: 04/12/2023

Defendant

Rebecca Konkin

TERMINATED: 04/12/2023

represented by **Brian A. Duus**
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TERMINATED: 04/12/2023
LEAD ATTORNEY

Jimmie E. Johnson , I
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TERMINATED: 04/12/2023

Louis Anthony Leone
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TERMINATED: 04/12/2023

Defendant

Tom Lando

TERMINATED: 04/12/2023

represented by **Brian A. Duus**
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LEAD ATTORNEY

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TERMINATED: 04/12/2023

Louis Anthony Leone
(See above for address)
TERMINATED: 04/12/2023

Defendant**Eileen Robinson***TERMINATED: 04/12/2023*represented by **Brian A. Duus**

(See above for address)

*TERMINATED: 04/12/2023**LEAD ATTORNEY***Jimmie E. Johnson , I**

(See above for address)

*TERMINATED: 04/12/2023***Louis Anthony Leone**

(See above for address)

*TERMINATED: 04/12/2023***Defendant****Matt Tennis***TERMINATED: 04/12/2023*represented by **Brian A. Duus**

(See above for address)

*TERMINATED: 04/12/2023**LEAD ATTORNEY***Jimmie E. Johnson , I**

(See above for address)

*TERMINATED: 04/12/2023***Louis Anthony Leone**

(See above for address)

TERMINATED: 04/12/2023

V.

Intervenor Defendant**GSA Network**represented by **Adam F. Shearer**

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ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
01/06/2023	<u>1</u>	COMPLAINT against All Defendants by Aurora Regino. (Filing fee \$ 402, receipt number ACAEDC-10632361) (Attachments: # <u>1</u> Exhibit A, # <u>2</u> Exhibit B, # <u>3</u> Exhibit C, # <u>4</u> Exhibit D, # <u>5</u> Exhibit E, # <u>6</u> Exhibit F, # <u>7</u> Civil Cover Sheet)(Dhillon, Harmeet) (Entered: 01/06/2023)
01/06/2023	<u>2</u>	MOTION for PRELIMINARY INJUNCTION by Aurora Regino. (Attachments: # <u>1</u> Memorandum, # <u>2</u> Exhibit A, # <u>3</u> Exhibit B, # <u>4</u> Proposed Order)(Dhillon, Harmeet) (Entered: 01/06/2023)
01/09/2023	<u>3</u>	SUMMONS ISSUED as to *Caitlin Dalby, Staley Kelly, Rebecca Konkin, Tom Lando, Eileen Robinson, Matt Tennis* with answer to complaint due within *21* days. Attorney *Harmeet Kaur Dhillon* *Dhillon Law Group, Inc.* *177 Post Street, Suite 700* *San Francisco, CA 94108*. (Mena-Sanchez, L) (Entered: 01/09/2023)
01/09/2023	<u>4</u>	CIVIL NEW CASE DOCUMENTS ISSUED (Attachments: # <u>1</u> Consent Form, # <u>2</u> Order re Filing Requirements, # <u>3</u> VDRP) (Mena-Sanchez, L) (Entered: 01/09/2023)

01/10/2023	5	MINUTE ORDER issued by Courtroom Deputy G. Michel for Senior Judge John A. Mendez on 1/10/2023: On the Court's own motion, the hearing on Plaintiff's Motion for Preliminary Injunction, ECF No. 2 , is SET for 2/14/2023 at 1:30 PM in Courtroom 6 before District Judge John A. Mendez. IT IS SO ORDERED. [TEXT ONLY ENTRY] (Michel, G.) (Entered: 01/10/2023)
01/20/2023	6	PRO HAC VICE APPLICATION and PROPOSED ORDER submitted by Aurora Regino for attorney Eric A. Sell to appear Pro Hac Vice. (Filing fee \$ 225, receipt number ACAEDC-10654067) (Dhillon, Harmeet) (Entered: 01/20/2023)
01/20/2023	7	PRO HAC VICE APPLICATION and PROPOSED ORDER submitted by Aurora Regino for attorney Joshua W. Dixon to appear Pro Hac Vice. Attorney Hoesly, Matthew Michael added. (Filing fee \$ 225, receipt number ACAEDC-10654321) (Hoesly, Matthew) (Entered: 01/20/2023)
01/20/2023	8	ORDER signed by Senior Judge John A. Mendez on 1/20/2023 GRANTING 6 Application for Pro Hac Vice. Attorney Eric A. Sell, to appear for Aurora Regino. The Pro Hac Vice attorney is directed to request electronic filing access through PACER. (Reader, L) (Entered: 01/20/2023)
01/20/2023	9	ORDER signed by Senior Judge John A. Mendez on 1/20/2023 GRANTING 7 Application for Pro Hac Vice. Attorney Joshua Wallace Dixon, to appear for Aurora Regino. The Pro Hac Vice attorney is directed to request electronic filing access through PACER. (Reader, L) (Entered: 01/20/2023)
01/24/2023	10	NOTICE of APPEARANCE by Michael A Columbo on behalf of Aurora Regino. Attorney Columbo, Michael A added. (Columbo, Michael) (Entered: 01/24/2023)
01/24/2023	11	MINUTE ORDER issued by Courtroom Deputy G. Michel for Senior Judge John A. Mendez on 1/24/2023: Before the Court is Plaintiff's motion for a preliminary injunction. <u>See</u> Mot. for Preliminary Injunction, ECF No. 2 . Federal Rule of Civil Procedure 65 requires that notice must be given to the adverse party prior to granting a preliminary injunction. Fed. R. Civ. P. 65(a)(1). It follows that the Court cannot order preliminary injunctive relief under Rule 65 until defendants have been provided with notice and an opportunity to be heard. To date, no defendant has formally appeared in the action and there is no entry on the docket reflecting service of summons and the complaint on any defendant. Further, Plaintiff has not shown that emergency circumstances warrant the issuance of an injunction without notice and hearing. Accordingly, Plaintiff's motion for a preliminary injunction is DENIED as premature without prejudice to renewal at a later date. The hearing set for February 14, 2023 is VACATED. IT IS SO ORDERED. [TEXT ONLY ENTRY] (Michel, G.) (Entered: 01/24/2023)
01/24/2023	12	[DISREGARD - see 17 Minute Order] STIPULATION and PROPOSED ORDER re 2 Motion for Preliminary Injunction Hearing by Aurora Regino. (Attachments: # 1 Proof of Service) (Columbo, Michael) Modified on 1/25/2023 (Michel, G.). (Entered: 01/24/2023)
01/24/2023	13	[DISREGARD - see 17 Minute Order] NOTICE TO RESCHEDULE HEARING re Motion for Preliminary Injunction. Motion Hearing RESET for 2/28/2023 at 1:30 PM

		in Courtroom 6 before Senior Judge John A. Mendez. (Attachments: # 1 Proof of Service) (Columbo, Michael) Modified on 1/25/2023 (Benson, A.). Modified on 1/25/2023 (Michel, G.). (Entered: 01/24/2023)
01/25/2023	14	NOTICE of APPEARANCE by Brian A. Duus on behalf of Caitlin Dalby, Staley Kelly, Rebecca Konkin, Tom Lando, Eileen Robinson, Matt Tennis. Attorney Duus, Brian A. added. (Duus, Brian) (Entered: 01/25/2023)
01/25/2023	15	NOTICE of APPEARANCE by Jimmie E. Johnson, I on behalf of Caitlin Dalby, Staley Kelly, Rebecca Konkin, Tom Lando, Eileen Robinson, Matt Tennis. Attorney Johnson, Jimmie E. added. (Johnson, Jimmie) (Entered: 01/25/2023)
01/25/2023	16	NOTICE of APPEARANCE by Louis Anthony Leone on behalf of Caitlin Dalby, Staley Kelly, Rebecca Konkin, Tom Lando, Eileen Robinson, Matt Tennis. Attorney Leone, Louis Anthony added. (Leone, Louis) (Entered: 01/25/2023)
01/25/2023	17	MINUTE ORDER issued by Courtroom Deputy G. Michel for Senior Judge John A. Mendez on 1/25/2023: On January 24, 2023, the Court denied Plaintiff's 2 Motion for Preliminary Injunction as premature without prejudice to renewal at a later date. <u>See</u> ECF No. 11 . Accordingly, the parties' Stipulation and Proposed Order, ECF No. 12 , and Notice to Reschedule Hearing, ECF No. 13 , are deemed moot and will not be considered by the Court. IT IS SO ORDERED. [TEXT ONLY ENTRY] (Michel, G.) (Entered: 01/25/2023)
01/25/2023	18	MOTION for PRELIMINARY INJUNCTION by Aurora Regino. Motion Hearing set for 2/28/2023 at 01:30 PM in Courtroom 6 before Senior Judge John A. Mendez. (Attachments: # 1 Notice, # 2 Memorandum , # 3 Exhibit 1, # 4 Exhibit 2, # 5 Exhibit 3, # 6 Proposed Order, # 7 Proof of Service)(Columbo, Michael) Modified on 1/26/2023 (Benson, A.). (Entered: 01/25/2023)
01/25/2023	19	STIPULATION and PROPOSED ORDER for Preliminary Injunction Hearing by Aurora Regino. (Attachments: # 1 Proof of Service Certificate of Service)(Columbo, Michael) (Entered: 01/25/2023)
01/27/2023	20	STIPULATION and ORDER signed by Senior Judge John A. Mendez on 01/26/2023 ORDERING that the Motion for Preliminary Injection shall be held on 2/28/2023 at 01:30 PM in Courtroom 6 before Senior Judge John A. Mendez, DIRECTING Defendants Kelly Staley, Caitlin Dalby, Rebecca Konkin, Tom Lando, Eileen Robinson and Matt Tennis to file any opposition briefing by 02/14/2023 and Plaintiff to file any reply briefing by 02/21/2023. (Spichka, K.) (Entered: 01/27/2023)
02/14/2023	21	OPPOSITION by Caitlin Dalby, et al., to 18 Motion for Preliminary Injunction. (Attachments: # 1 Request for Judicial Notice, # 2 Declaration of Jimmie E. Johnson, # 3 Declaration of Kelly Staley, # 4 Objections to Expert Affidavit)(Johnson, Jimmie) (Entered: 02/14/2023)
02/14/2023	22	MOTION to INTERVENE by GSA Network. Attorney Shearer, Adam F. added. Motion Hearing set for 3/28/2023 at 01:30 PM in Courtroom 6 (JAM) before Senior Judge John A. Mendez. (Attachments: # 1 Declaration of Ginna Brelsford, # 2 [STRICKEN - see 32 Order] Proposed Opposition to Motion for Preliminary

		Injunction, # 3 [STRICKEN - see 32 Order] Declaration of Dr. Jack Turban, # 4 Conditional Answer, # 5 Proposed Order)(Shearer, Adam) Modified on 2/24/2023 (Michel, G.). (Entered: 02/14/2023)
02/16/2023	23	NOTICE of APPEARANCE by Jennifer Ling Chou on behalf of GSA Network. Attorney Chou, Jennifer Ling added. (Chou, Jennifer) (Entered: 02/16/2023)
02/16/2023	24	NOTICE of APPEARANCE by Elizabeth O. Gill on behalf of GSA Network. Attorney Gill, Elizabeth O. added. (Gill, Elizabeth) (Entered: 02/16/2023)
02/16/2023	25	NOTICE of APPEARANCE by Amanda Goad on behalf of GSA Network. Attorney Goad, Amanda added. (Goad, Amanda) (Entered: 02/16/2023)
02/16/2023	26	NOTICE of APPEARANCE by Ariana Rodriguez on behalf of GSA Network. Attorney Rodriguez, Ariana added. (Rodriguez, Ariana) (Entered: 02/16/2023)
02/21/2023	27	REPLY by Aurora Regino in support of 18 Motion for Preliminary Injunction. (Attachments: # 1 Response, # 2 Declaration)(Dhillon, Harmeet) (Entered: 02/21/2023)
02/21/2023	28	MOTION to STRIKE by Aurora Regino. Motion Hearing set for 4/4/2023 at 01:30 PM before Senior Judge John A. Mendez. (Attachments: # 1 Notice, # 2 Proposed Order) (Dhillon, Harmeet) (Entered: 02/21/2023)
02/21/2023	29	REQUEST for JUDICIAL NOTICE by Aurora Regino in re 27 Reply re Motion for Preliminary Injunction. (Attachments: # 1 Response)(Dhillon, Harmeet) Modified on 2/22/2023 (Benson, A.). (Entered: 02/21/2023)
02/23/2023	30	MINUTE ORDER issued by Courtroom Deputy G. Michel for Senior Judge John A. Mendez on 2/23/2023: Plaintiff's 28 Motion to Strike is noticed for hearing on a date not designated for the Court's civil law and motion calendar. Consequently, the hearing set for 4/4/2023 is VACATED and RESET for 3/28/2023 at 1:30 PM in Courtroom 6 before Senior Judge John A. Mendez. [TEXT ENTRY ONLY] (Michel, G.) (Entered: 02/23/2023)
02/23/2023	31	OBJECTIONS by Defendants Caitlin Dalby, et al., to 27 Reply Evidence in support of Motion. (Johnson, Jimmie) Modified on 2/23/2023 (Benson, A.). (Entered: 02/23/2023)
02/24/2023	32	ORDER signed by Senior Judge John A. Mendez on 2/24/2023 GRANTING 28 Motion to Strike; ORDERING that the docket entries at ECF Nos. 22-2 and 22-3 be stricken from the record. (Michel, G.) (Entered: 02/24/2023)
02/28/2023	33	MINUTES (Text Only) for MOTION HEARING before Senior District Judge John A. Mendez held on 02/28/2023. Plaintiff's counsel, Eric Sell and Joshua Dixon, present. Defendants' counsel, Brian Duus, present. The court and counsel discussed the pending motion. Arguments heard. The court SUBMITTED Plaintiff's 18 Motion for Preliminary Injunction. A written order to issue. Court Reporter: M. Valenoti. (York, M) (Entered: 02/28/2023)
02/28/2023	34	OPPOSITION by Aurora Regino to 22 Motion to Intervene,. Attorney Graham, Jeremiah added. (Graham, Jeremiah) (Entered: 02/28/2023)
03/01/2023	35	TRANSCRIPT REQUEST by GSA Network for proceedings held on 02-28-2023

		before Judge Hon. John A. Mendez. Court Reporter Maryann Valenoti. (Shearer, Adam) (Entered: 03/01/2023)
03/08/2023	36	TRANSCRIPT of Motion Hearing Proceedings held on February 28, 2023, before Senior Judge John A. Mendez, filed by Court Reporter Maryann Valenoti, Phone number 916-930-4275 E-mail mvalenotirmcrr@gmail.com. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction must be filed within 5 court days. Redaction Request due 3/30/2023. Redacted Transcript Deadline set for 4/10/2023. Release of Transcript Restriction set for 6/8/2023. (Valenoti, Maryann) (Entered: 03/08/2023)
03/09/2023	37	ORDER signed by Senior Judge John A. Mendez on 03/08/2023 DENYING 18 Motion for Preliminary Injunction. (Rodriguez, E) (Entered: 03/09/2023)
03/10/2023	38	REPLY by GSA Network in support of 22 Motion to Intervene. (Shearer, Adam) Modified on 3/15/2023 (Rodriguez, E). (Entered: 03/10/2023)
03/21/2023	39	MINUTE ORDER (Text Only Entry) issued by M York Courtroom Deputy for Senior District Judge John A. Mendez on 03/21/2023: GSA Network's 22 Motion to Intervene now calendared for 03/28/2023 is SUBMITTED without appearance and without oral argument pursuant to Local Rule 230(g). As such, the hearing on said motion is VACATED. If the Court subsequently concludes that oral argument is necessary, a hearing will be set and the parties notified accordingly. (York, M) (Entered: 03/21/2023)
03/27/2023	40	MOTION to DISMISS by Caitlin Dalby, et al.. Motion Hearing set for 5/23/2023 at 01:30 PM in Courtroom 6 (JAM) before Senior Judge John A. Mendez. (Attachments: # 1 Request for Judicial Notice, # 2 Declaration of Jimmie Johnson , # 3 Declaration of Kelly Staley , # 4 Index of Exhibits, # 5 Exhibit A, # 6 Exhibit B , # 7 Exhibit C , # 8 Exhibit D , # 9 Exhibit E, # 10 Exhibit F)(Johnson, Jimmie) Modified on 3/28/2023 (Kastilahn, A). (Entered: 03/27/2023)
03/27/2023	41	JOINT RULE 26(F) REPORT filed by Defendants Caitlin Dalby, Rebecca Konkin, Tom Lando, Eileen Robinson, Kelly Staley, Matt Tennis. (Johnson, Jimmie) Modified on 3/28/2023 (Kastilahn, A). (Entered: 03/27/2023)
04/10/2023	42	FIRST AMENDED COMPLAINT against All Defendants by Aurora Regino. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Proof of Service)(Dhillon, Harmeet) (Entered: 04/10/2023)
04/10/2023	43	OPPOSITION by Plaintiff Aurora Regino to 40 Motion to Dismiss. (Attachments: # 1 Proof of Service)(Dhillon, Harmeet) (Entered: 04/10/2023)
04/11/2023	44	REPLY by Caitlin Dalby, Rebecca Konkin, Tom Lando, Eileen Robinson, Kelly Staley, Matt Tennis re 43 Opposition, 40 Motion to Dismiss, 42 Amended Complaint. (Johnson, Jimmie) (Entered: 04/11/2023)
04/12/2023	45	MINUTE ORDER (Text Only Entry) issued by M York Courtroom Deputy for Senior District Judge John A. Mendez on 04/12/2023: On 04/10/2023, Plaintiff timely filed her

		First Amended Complaint in response to Defendants' Motion to Dismiss at ECF No. 40 . See FAC, ECF No. 42 ; Fed. R. Civ. P. 15(a)(1)(B). An amended complaint ordinarily moots a motion to dismiss, however, the Court may exercise its discretion to consider a motion to dismiss the original complaint where the amended complaint fails to cure the defects of the original complaint. <u>Appleton v. County of Sacramento</u> , 2005 U.S. Dist. Lexis 35632, fn. 4 (E.D. Cal. Dec. 25, 2005). Accordingly, the Court GRANTS in PART and DENIES in PART Defendants' Motion to Dismiss. The Court GRANTS Defendants' motion as to the individual Board Member Defendants sued in their official capacities. The claims against Defendants Caitlin Dalby, Rebecca Konkin, Tom Lando, Eileen Robinson, and Matt Tennis, sued in their official capacities, are hereby DISMISSED with prejudice. As to any other issues raised in the Motion to Dismiss, the Court will take them up at the appropriate time if Defendants file a second motion to dismiss the FAC. The Court thus DENIES the remainder of Defendants' motion without prejudice for refiling. The Court also DENIES Defendant's Request for Judicial Notice without prejudice for refiling. ECF No. 40-1 . The 05/23/2023 hearing on this Motion is hereby VACATED. (York, M) (Entered: 04/12/2023)
04/17/2023	46	ORDER signed by Senior Judge John A. Mendez on 4/14/2023 DENYING 22 Motion to Intervene. (Perdue, C.) (Entered: 04/17/2023)
04/17/2023	47	TRANSCRIPT REQUEST by Aurora Regino for proceedings held on 2/28/2023 before Judge John A. Mendez. Court Reporter Maryann Valenoti. (Dhillon, Harmeet) (Entered: 04/17/2023)
04/18/2023	48	STIPULATION and PROPOSED ORDER for 5-Page Limit Extension On Def Kelly Staley's Forthcoming Rule 12 Mtn and Pltf's Opp Thereto by Caitlin Dalby et al., (Johnson, Jimmie) Modified on 4/19/2023 (Licea Chavez, V). (Entered: 04/18/2023)
04/20/2023	49	MINUTE ORDER (Text Only Entry) issued by M York Courtroom Deputy for Senior District Judge John A. Mendez on 04/20/2023: Upon careful review, the Court DECLINES TO ADOPT the parties 48 Stipulation and Proposed Order re Page Limits. The parties shall comply with the page limits set forth in the Court's 4 -2 Order re Filing Requirements when filing the forthcoming motion and related briefing referenced in their stipulation. (York, M) (Entered: 04/20/2023)
04/25/2023	50	MOTION to DISMISS by Kelly Staley. Motion Hearing set for 6/27/2023 at 01:30 PM in Courtroom 6 (JAM) before Senior Judge John A. Mendez. (Johnson, Jimmie) (Entered: 04/25/2023)
04/25/2023	51	REQUEST for JUDICIAL NOTICE by Kelly Staley in re 50 Motion to Dismiss. (Attachments: # 1 Johnson Declaration, # 2 Staley Declaration, # 3 Exhibit A , # 4 Exhibit B, # 5 Exhibit C, # 6 Exhibit D)(Johnson, Jimmie) Modified on 4/26/2023 (Benson, A.). (Entered: 04/25/2023)
05/09/2023	52	OPPOSITION by Aurora Regino to 50 Motion to Dismiss. (Dhillon, Harmeet) (Entered: 05/09/2023)
05/09/2023	53	OPPOSITION to 51 Request for Judicial Notice by Aurora Regino . (Dhillon, Harmeet) Modified on 5/10/2023 (Licea Chavez, V). (Entered: 05/09/2023)

05/16/2023	54	REPLY by Caitlin Dalby, Rebecca Konkin, Tom Lando, Eileen Robinson, Kelly Staley, Matt Tennis re 50 Motion to Dismiss. (Johnson, Jimmie) (Entered: 05/16/2023)
06/13/2023	55	MINUTE ORDER (Text Only Entry) issued by M York Courtroom Deputy for Senior District Judge John A. Mendez on 06/13/2023: The parties are ORDERED to file an <u>updated</u> Joint Status Report pursuant to the provisions of F.R.Cv.P. 16 and 26, in accordance with Local Rule 240 and the Court's Order Requiring Service of Process and Joint Status Report, within thirty (30) days after the Court's ruling on Defendant's pending 50 Motion to Dismiss. (York, M) (Entered: 06/13/2023)
06/27/2023	56	MINUTES (Text Only) for MOTION HEARING before Senior District Judge John A. Mendez held on 06/27/2023. Plaintiff's counsel, Joshua Dixon, present along with his client Aurora Regino. Defendant's counsel, Brian Duus, present. The Court and counsel discussed the pending motion. Arguments heard.The court SUBMITTED Defendant's 50 Motion to Dismiss. A written order to issue. Court Reporter: Maryann Valenoti. (York, M) (Entered: 06/27/2023)
07/11/2023	57	ORDER signed by Senior Judge John A. Mendez on 7/10/2023 GRANTING 50 Motion to Dismiss, all of Plaintiff's claims are DISMISSED with prejudice. CASE CLOSED (Reader, L) (Entered: 07/11/2023)
07/11/2023	58	JUDGMENT dated *7/11/2023* pursuant to order signed by Senior Judge John A. Mendez on 7/10/2023. (Reader, L) (Entered: 07/11/2023)
07/20/2023	59	NOTICE of APPEAL by Aurora Regino. (Filing fee \$ 505, receipt number ACAEDC-10972582) (Dhillon, Harmeet) (Entered: 07/20/2023)
07/21/2023	60	APPEAL PROCESSED to Ninth Circuit re 59 Notice of Appeal filed by Aurora Regino. Notice of Appeal filed *7/20/2023*, Complaint filed *1/6/2023* and Appealed Order / Judgment filed *7/11/2023*. Court Reporter: *Maryann Valenoti*. *Fee Status: Paid on 7/20/2023 in the amount of \$505.00* (Attachments: # 1 Appeal Information) (Reader, L) (Entered: 07/21/2023)
07/26/2023	61	TRANSCRIPT REQUEST by Aurora Regino. Court Reporter Maryann Valenoti. (Dhillon, Harmeet) (Entered: 07/26/2023)
07/28/2023	62	USCA CASE NUMBER 23-16031 for 59 Notice of Appeal filed by Aurora Regino. (Licea Chavez, V) (Entered: 07/28/2023)
08/17/2023	63	TRANSCRIPT of Motion to Dismiss Proceedings held on June 27, 2023, before Senior Judge John A. Mendez, filed by Court Reporter Maryann Valenoti, Phone number 916-930-4275 E-mail mvalenotirmrcrr@gmail.com. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction must be filed within 5 court days. Redaction Request due 9/8/2023. Redacted Transcript Deadline set for 9/18/2023. Release of Transcript Restriction set for 11/16/2023. (Valenoti, Maryann) (Entered: 08/17/2023)
09/08/2023	64	MOTION to PUBLISH by Kelly Staley. Motion Hearing set for 10/10/2023 at 01:30 PM in Courtroom 6 (JAM) before Senior Judge John A. Mendez. (Johnson, Jimmie)

		Modified on 9/11/2023 (Licea Chavez, V). (Entered: 09/08/2023)
09/13/2023	65	MINUTE ORDER (Text Only Entry) issued by M York Courtroom Deputy for Senior District Judge John A. Mendez on 09/13/2023: Defendant's 64 Motion to Publish is noticed for hearing on a date not designated for the Court's civil law and motion calendar. Consequently, the hearing set for 10/10/2023 is VACATED. Counsel shall contact M York, Courtroom Deputy for District Judge John A. Mendez, via email to obtain an available date to re-notice the motion for hearing. Ms. York can be reached at: MYork@caed.uscourts.gov . (York, M) (Entered: 09/13/2023)
09/25/2023	66	NOTICE to RESCHEDULE HEARING on 64 Motion to Publish: Motion Hearing SET for 10/31/2023, at 01:30 PM, in Courtroom 6 (JAM), before Senior District Judge John A. Mendez. (Johnson, Jimmie) Modified on 9/29/2023 (York, M). (Entered: 09/25/2023)
10/19/2023	67	MINUTE ORDER (Text Only Entry) issued by M Francel Relief Courtroom Deputy for Senior District Judge John A. Mendez on 10/19/2023: Defendant's 64 Motion to Publish now calendared for 10/31/2023 is SUBMITTED without appearance and without oral argument pursuant to Local Rule 230(g). As such, the hearing on said motion is VACATED. If the Court subsequently concludes that oral argument is necessary, a hearing will be set and the parties notified accordingly. (Francel, M.) (Entered: 10/19/2023)
10/26/2023	68	MINUTE ORDER (Text Only Entry) issued by M. Francel Relief Courtroom Deputy for Senior District Judge John A. Mendez on 10/26/2023: The Court has received, read and considered Defendant Kelly Staley's unopposed "Motion to Publish ECF 57 in National Reporter System" (ECF No. 64). The Court's Order Granting Defendant's Motion to Dismiss (ECF No. 57) has been appealed to the Ninth Circuit (ECF No. 59) and is pending before that Court. This Court cannot order that a publishing company publish its decision but can only recommend that a specific order be published. Additionally, as Defendant acknowledges, the decision to recommend publication is at the Court's discretion. Given the current status of this case, this Court respectfully DECLINES Defendant's request and DENIES her motion to publish at this time. (Francel, M.) (Entered: 10/26/2023)

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