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21 SUPERIOR COURT OF THE STATE OF CALIFORNIA

22 IN AND FOR THE COUNTY OF SAN JOAQUIN – STOCKTON BRANCH

23 CHLOE E. BROCKMAN aka CHLOE
24 COLE, an individual

25 Plaintiff,

26 v.

27 KAISER FOUNDATION HOSPITALS,
28 INC., a California Corporation, THE
PERMANENTE MEDICAL GROUP, INC.,
a California Corporation, LISA KRISTINE
TAYLOR, M.D., an individual, HOP
NGUYEN LE, M.D., an individual,
SUSANNE E. WATSON, PHD., an
individual, LILIT ASULYAN PSYD, an
individual, and ESTER BALDWIN, LCSW,
an individual, and DOES 1 through 50,
inclusive,

Defendants.

Case No.: STK-CV-UMM-2023-0001612

**DECLARATION OF ROBIN A. DEA,
M.D.**

Dept.: 11B
Judge: Hon. Robert T. Waters
Assigned for All Purposes

Action Filed: February 22, 2023
Trial Date: Not Set

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DECLARATIN OF ROBIN DEA, M.D.

I, Robin Dea, M.D., declare as follows:

1. I am a physician that has been retained by Plaintiff Chloe E. Brockman as an expert witness in the above-captioned matter.

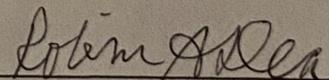
2. I make this declaration in support of Plaintiff's Motion for Leave to Amend Complaint to State Claim for Punitive Damages.

3. I am over the age of eighteen and am competent to testify as to the matters herein. The following is based on personal knowledge unless otherwise stated.

4. Attached hereto as **Exhibit 1** is a true and correct copy of my curriculum vitae.

5. Attached hereto as **Exhibit 2** is a true and correct copy of my signed Report of Findings on Chloe Brockman, including Appendix A and Appendix B thereto.

I declare until penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on Feb 5, 2024, at Puerto Vallarta, Jalisco, Mexico



Robin Dea, M.D.

EXHIBIT 1

Robin A. Dea, M.D.

Chair, Chiefs of Psychiatry
Kaiser-Permanente
Northern California

Education:

<u>University</u>	<u>Degree</u>	<u>Year</u>
University of New Mexico, Albuquerque, New Mexico	B.S.	1968
University of New Mexico, Albuquerque, New Mexico	M.D.	1976
Internship, Highland Hospital, Oakland, California		1977
Psychiatric Residency, California Pacific Medical Center, San Francisco, California		1979

Professional Experience:

1979-2008	Staff Psychiatrist, Dept. of Psychiatry, Kaiser Permanente Medical Center, Redwood City
1980-1981	Assistant Chief, Dept. of Psychiatry, Kaiser Permanente Medical Center, Redwood City
1981-1997	Chief, Dept. of Psychiatry, Kaiser Permanente Medical Center, Redwood City
1987-1989	Chair, Chiefs of Psychiatry, Northern California Kaiser-Permanente
1988-1996	West Bay Sub-Regional Inpatient Psychiatry Chief, Kaiser Permanente
1991-2009	Regional Director, Mental Health Services, and Chair, Chiefs of Psychiatry, Northern California Kaiser-Permanente

Professional Society Affiliations:

- a) American Psychiatric Association
- b) National Leadership Council, Institute for Behavioral Health, 1993-96
- c) Northern California Psychiatric Association-Councilor, elected 2007
- d) California Medical Association
- e) Association of Gay and Lesbian Psychiatrists
- f) World Professional Association for Transgender Health
- g) Institute for Behavioral Healthcare Improvement, 2006-2012, Secretary, Board of Directors

Presentations

September 27, 1993

Behavioral Healthcare Tomorrow, San Francisco, "Carve-Outs, HMOs or Public-Private Partnerships: What is the Best Behavioral Benefit Program for Self-Insured Employers"

September 11, 1994

Behavioral Healthcare Tomorrow, Washington, D.C., "Overview of Primary Care Integration"

September 10, 1996

Behavioral Healthcare Tomorrow, San Francisco, CA, "Integrating Behavioral Healthcare and Primary Care"

November 15, 1996

"Redefining Psychiatric Inpatient Care and Developing Intensive Outpatient Programs," Kaiser-Permanente National Conference on Quality, San Jose Convention Center, San Jose, CA

February 3, 1997

"Guidelines for Treating Depression", Kaiser-Permanente Internal Medicine Guidelines Conference, Palm Springs, CA

February 21, 1997

"Treating Depression in Primary Care", Kaiser-Permanente Primary Care/Musculoskeletal Conference, Kauai, HI

May 29, 1997: Alain Enthoven, PhD, Robin Dea, MD: "Delivering Medical Care in a Business World: Cutting Medical Costs Without Cutting Quality," Regional videoconference, Kaiser-Permanente, Northern California

July 20-25, 1997 Kaiser-Permanente Internal Medicine Conference, Kauai, HI

"The Recognition & Treatment of Depression in Primary Care"

“The Integration of Mental Health and Chemical Dependency Care with Primary Care”

“Cognitive Behavioral Therapy Skills In Primary Care”

August 13, 1997

“Insurer View of Underwriting and Providing Mental Health Care Coverage,” Bar Association of San Francisco, San Francisco, CA

Spine Specialist & Disability Management Training Workshop: “Advanced Lessons In the Management of Disability for Occupational Low Back Problems: Case History Based Learning Session”

Santa Clara 5/9/97, Hayward 5/23/97, Vallejo 5/30/97, San Rafael 6/6/97, Roseville 6/27/97

October 17, 1997

“Treating Patients with Gender Dysphoria,” Kaiser-Permanente Annual Regional Psychiatry Conference, San Francisco, CA.

November 11, 1997

“Creating Carve-In Behavioral Health Services for Primary Care Settings” (with Anina Schwartz, MD), Institute for Behavioral Healthcare sponsored Primary Care/Behavioral Healthcare Summit, Chicago, Illinois

March 27, 1998

“Care for the least well off in a Group Model HMO Setting,” Sponsored by Undersecretary for Veterans Affairs, US Veterans Administration. Washington, D.C.

September 18, 1998

“Pricing & Delivering Integrated Managed Behavioral Healthcare: The Kaiser-Permanente Model,” Institute for Behavioral Healthcare sponsored Behavioral Healthcare Tomorrow Conference, Chicago, Illinois.

March 29, 1999

1. “Diagnosis and Management of Depression in the Primary Care Setting,”
2. “Disability Management Communication Skills Workshop: Focus on Empathy, Listening & Brief Negotiation” at Improving Clinical Outcomes & Professional Satisfaction In Primary Care Practice, Sponsored by Kaiser-Permanente, Maui, Hawaii.

September 24, 1999

“Key Controversies in Behavioral Healthcare,” a Town Hall Forum, at Institute for Behavioral Healthcare sponsored Behavioral Healthcare Tomorrow Conference in San Francisco, California.

October 5, 1999

“Finding Your Way: Depression, Stress and Anxiety,” California Governor’s Conference for Women, Long Beach, California.

October 19, 1999

“Psychiatric Aspects of Gender Dysphoria,” Tom Waddell Clinic, San Francisco, California

April 27, 2000

1. “Diagnosis and treatment of depression in the Primary Care setting,”
 2. “Sociological Aspects of Women’s Health,”
- The Kaiser-Permanente National Primary Care Conference, Kauai, Hawaii

June 16, 2000

“Integration of Behavioral Healthcare with Primary Care,” New York City Mental Health Department, New York, New York

January 12, 2001

"Full Data Capture for Medicare Compliance," Kaiser Permanente Northern California Region videoconference, Oakland, California

January 9 and 16, 2001

"Managing in a Union Environment," Kaiser Permanente Northern California Region manager training.

March 31, 2001

"Detection and Treatment of Depression in Primary Care," Kaiser Permanente Medical Center, Redwood City, California.

April 2, 2001

"The Group Model HMO Approach to Large Simple Trials," at Large Simple Trials in the Neurosciences: Dementia, Depression and Schizophrenia, by Drug Information Association-Europe, St. Catherine's College, Oxford, England.

May 9, 2001

"Evaluation and Treatment of Female to Male Transgendered Patients," Component Workshop, American Psychiatric Association Annual Conference, New Orleans, Louisiana

December 10, 2001

"Enhancing Compliance with Depression Treatment," Kaiser-Permanente, Santa Clara, California.

March 29, 2002

"Depression in Women Throughout the Lifespan," Kaiser-Permanente National Primary Care Conference, Maui, Hawaii.

April 11, 2002

"Depression, Beyond the Basics," Kaiser-Permanente Northern California Regional Videoconference.

October 13, 2002

"Depression in Women Throughout the Lifespan," Kaiser-Permanente National Primary Care Conference, Anaheim, California

March 29, 2003

"The Integration of Behavioral Healthcare with Primary Care," National Council for Community Behavioral Healthcare, Denver, Colorado

May 20, 2003

"Intimate Partner Violence and Abuse: Identification and Intervention Within a Behavioral Health Study," Workshop at the American Psychiatric Association Annual Meeting, San Francisco, California.

March 2004

"Behavioral Medicine in Primary Care," Institute for Healthcare Improvement, San Francisco, California

May 4, 2004

"Kaiser-Permanente Model of Care-Integrated Urgent Services," National Institute for Mental Health in England, London, England

May 6, 2004

"An American Model of Care-What We Can Learn from Each Other," National Mental Health Partnership Annual Conference, National Health Service, York, England

April 2, 2005

"The Biology of Gender, from Chromosomes to Brain Nuclei," Annual Meeting, Northern California Psychiatric Society, Napa California

April 13, 2006

"Transgender Health Care," Regional Videoconference, Kaiser Permanente Northern California, Oakland, California

July 12, 2006

"Behavioral Health Standards and Stories of Success (The Institute of Medicine Report on Behavioral Health, and KP Advances)," Kaiser Permanente National Quality Conference, Denver, Colorado

July 27, 2006

"Leveraging Non-traditional Reporting Methods-Data Graphics Provider Profiling System," World Research Group Conference, San Francisco, California

October 5, 2006

"Grand Rounds: Intimate Partner Abuse: How Important Is It?," Department of Psychiatry and Behavioral Sciences, Stanford University Medical Center, Stanford, California

November 10, 2006

"The Biology of Gender," Regional Cultural Diversity Conference, Kaiser Permanente, Northern California, Vacaville, California.

December 11, 2006

"Multi-system Integration in a Group Model Pre-paid Healthcare System: The Kaiser Permanente Model," Institute for Behavioral Healthcare Improvement, Orlando, Florida

March 24, 2007

"How Much Do Relationships Matter?," Kaiser Permanente Regional Psychiatry Conference, Keynote Address, San Francisco, California

September 19, 2007

"Sensitive Treatment of Transgender Patients in Chemical Dependency Day Program," Kaiser Permanente Chemical Dependency Day Treatment Program, San Francisco, California

December 9, 2007

"Integrating Behavioral and General Medical Healthcare: Opportunities and Challenges," Second Colloquium on Improving Collaboration and Integration of Care, Institute for Behavioral Healthcare Improvement, Caribe Royale Hotel, Orlando, Florida.

January 17, 2008

"Integrating Behavioral Healthcare and Disease Management in an HMO," Heel de Mens, Heel de Zorg, GGZ Kennisdag, Trimbos Institute (Netherlands Institute of Mental Health and addiction), Amsterdam, Netherlands

November 11, 2008

"Sexual Assignment and Management of the Transgender Individual," American Society for Reproductive Medicine, San Francisco, California.

January 17, 2009

"Transgender Mental Health Through the Life Cycle," at Sexual Orientation and Gender Identity in Primary Care, General Medicine and Mental Health, University of California at Davis, Sacramento, California

March 24, 2010

"Webcare for Depression" presented to Chiefs of Psychiatry, Northern California Kaiser Permanente, 1950 Franklin St., Oakland, California.

November 19, 2013

"Managing the Behavioral Healthcare Patient in Medical Settings", Behavioral Health Initiative sponsored by Michigan Professional Review Organization (MPRO), Livonia, Michigan

November 20, 2013

"Evaluation of Depression: PHQ9", "Implementation Practice," Behavioral Health Initiative sponsored by Michigan Professional Review Organization (MPRO), Livonia, Michigan

Publications

Dea, R. A., "The Myth of the Superwoman", Peninsula Magazine, June 1988

Dea, R. A., "Can HMOs Create High Quality Managed Behavioral Benefits Programs?" Managed Healthcare News, April 1993

Dea, R. A., Integration of Mental Health and Chemical Dependency Care with Primary Care, HMO Practice, December 1996,10;4:163-165

Dea, R. A. "The Integration Experience in a Group Model HMO: the Northern California Experience," in: Haber, J.D., Mitchell, G.E., Primary Care Meets Mental Health: Tools For The 21st Century, 1997.

Rosenheck, R., Armstrong, M., Callahan, D., Dea, R., Del Vecchio, P., Flynn, L., Fox, R., Goldman, H., Horvath, T., Munoz, R., Obligation to the Least Well Off in Setting Mental Health Service Priorities: A Consensus Statement. Psychiatric Services 49:1273, 1998

Contributor in: Steinberg, A., Gadomski, A., Wilson, M., Children's Mental Health: The Changing Interface Between Primary and Specialty Care: Report of the Children's Mental Health Alliance Project, Philadelphia, PA, 1999.

Arnow, B., Hart, S., Scott, C., Dea, R., O'Connell, L., Taylor, C., Childhood Sexual Abuse, Psychological Distress, and Medical Use Among Women. Psychosomatic Medicine 61(6):762-770, 1999.

Dea, R. A., The Integration of Primary Care and Behavioral Healthcare in Northern California Kaiser-Permanente, Psychiatric Quarterly, 71(1):17-29, Spring 2000

Newman, M.G., Clayton, L., Zuellig, A., Cashman, L., Arnow, B., Dea, R., Taylor, C.B., The Relationship of Childhood Sexual Abuse and Depression with Somatic Symptoms and Medical Utilization, Psychological Medicine, 2000, 30, 1063-1077.

Arnow BA, Hart S, Hayward C, Dea R, Taylor CB: Severity of child maltreatment history, pain complaints and medical utilization among women. J Psychiatric Research 2000; 34:413-421.

Hunkeler, E., Fireman, B., Lee, J., Diamond, R., Hamilton, J., He, C.X., Dea, R., Nowell, W., Hargreaves, W., Trends in Use of Antidepressants, Lithium, and Anticonvulsants In Kaiser Permanente Insured Youths, 1994-2003. Journal of Child and Adolescent Psychopharmacology, Volume 15 Number 1, 2005

Arnow, B., Hunkeler, E., Blasey, C., Lee, J., Constantino, M., Fireman, B., Kraemer, H., Dea, R., Robinson, R., Hayward, C., Comorbid Depression, Chronic Pain and Disability in Primary Care, Psychosomatic Medicine 68: 262-268 (2006)

Arnow BA, Blasey CM, Lee J, Fireman B, Hunkeler EM, Dea R, Robinson R, Hayward C., Relationships among depression, chronic pain, chronic disabling pain, and medical costs. Psychiatr Serv. 2009 Mar;60(3):344-50.

Hunkeler, EM, Hargreaves, WA, Fireman, B, Terdiman, J, Meresman, JF, Porterfield, Y, Lee, J, Dea, R, Simon, G, Bauer, M, Unutzer, J, Taylor, CB; A Web-Delivered Care Management and Patient Self-Management Program for Recurrent Depression: A Randomized Trial. *Psychiatric Services*, 63 (11) 1063-1071.

Awards

Oct 18, 2000

U.S. House of Representatives, Certificate of Special Congressional Recognition, in recognition of outstanding and invaluable service to the community, Anna G Eshoo, Member of Congress

October 2000

California State Senate, Certificate of Recognition, Leadership in serving people with mental illness, Byron D. Sher, Member of the State Senate

December 2000

California State Assembly, Certificate of Recognition, 2000 Mental Illness Awareness Award, Ted Lempert, Member of the Assembly

Sept. 19, 2004

California Legislature, Assembly Certificate of Recognition, Mark Leno, Assemblyman, 13th District

2004

Lyon-Martin Womens' Health Services Honoree-Warrior

May 14, 2009

Cecil Cutting Leadership Award. Kaiser Permanente, Northern California

EXHIBIT 2

May 12, 2023

Report of Findings on Chloe Brockman

Gender identity is an innate sense of self as either male or female. While there is currently much political and ideological discussion by adults claiming multiple genders, in childhood that is not the case. In the scientific writings from Denmark regarding Christine Jorgensen to the landmark text The Transsexual Phenomenon by Harry Benjamin, transsexualism was seen as being separate from other sex or sexuality-based issues, such as transvestism and homosexuality. The primary differentiating factor between these issues was the concept of core gender identity. Transsexuals had a core gender identity reversal, with biologic males having a female identity and biologic females having a male identity. This is quite different from transvestites, who typically had a male gender identity but were strongly attracted to wearing female clothing and associating with other transvestites. During the early 1900's female transvestism was rarely studied, and most females who dressed as males were clinically considered lesbian. Homosexuals have a gender identity congruent with their anatomical sex but are sexually attracted to their same sex. In today's world of the "non-binary" community, these distinctions are blurred, and people with no knowledge of either the psychological or biological development of gender identity, speak profoundly and loudly on what medical care should be and how laws should be shaped to their benefit.

The literature of gender non-conforming behavior in children was intermittent in the papers of Harry Benjamin, but became known internationally with the publication of The Sissy Boy Syndrome by Richard Green in 1987 (see Appendix A). He followed 66 young males identified with cross-gender behavior and by age 18 had contact with 44 of those young people. He found only one transsexual by age 18, with all of the other males identifying themselves as male, roughly equally split between heterosexual and homosexual. Other studies since that time (Appendix A) have found similar outcomes when following male and female children with cross-gender identification, with results showing 65-85% of children do not remain transgendered by age 20.

In the evaluation of children, early childhood core gender identity is important, as is the timing of when it appears. The later a child reports cross-gender feelings, the less likely there is a core gender identity conflict, but as with those who do have early-onset, many factors need to be explored to make a diagnosis. That raises the question of what was occurring in the 60-80% of the children from these studies who did not feel transgendered as young adults. Children's brains do not really start to abstract until around age 12-13. Children's thinking is fairly concrete, so frequently boys who feel "feminine" or enjoy toys and socializing they associate with girls can see themselves as like girls. Girls who feel or behave more like boys can see themselves as like boys. As in the listed studies, by going through puberty and having their brains mature, many of these children find themselves as young adults who are gay or lesbian, and some see themselves as heterosexuals, with a gender identity consistent with their sex at birth. Those who persist in feeling cross-gendered may be transsexuals but seem to be only 20-40% of those identified as children with cross-gender feelings. Parents who identify their 4-7 year-olds as "trans" are risking pushing them into a transgender view of themselves, when in fact they may eventually be either gay or heterosexual.

The evaluation of children requires looking at core gender identity and gender role behavior precisely because they are not the same thing. A 7 year-old boy playing house with the girls is not a sign of transgender behavior; nor is "tomboyism" in girls. Young children have not developed enough to have a

sense of sexual attraction, which even at its earliest doesn't begin to manifest until age 11-13, and even then, sexual orientation evolves over years for many individuals.

A crucial question today, with gender transition clinics springing up around the US is this: If you knew that the child you are evaluating would turn out to be gay by age 18 instead of transgender, would you still push for them to have "gender affirming care" including puberty blockers and cross-sex hormones? The scientific research clearly shows that the overwhelming majority of gender non-conforming children do not become transsexual. Between the ages of 9-11, do there exist scientific studies that show the clinicians can clearly tell the difference between those that will and those that won't become transsexual? The answer is no. To treat children with hormones and puberty blockers is to subject a majority of such children to inappropriate treatment, which is clearly unethical. The ethical stance is to offer supportive psychotherapy, clearly outlining for children and parents the potential outcomes, and allowing the child to mature enough to make a decision in late adolescence.

This is where the concept of gender role behavior becomes important in the evaluation of children and adults. Experts on male/female differences such as Dr. Jordan Peterson make it clear that the range of gender role behavior within each sex is just as great as that between the sexes. Effeminate males and ultra-male body builders are on a continuum of gender role behavior, but both still have a male gender identity. Ultra-feminine females and "butch" women have very different gender role behaviors, but still have female gender identity.

The role of the clinician evaluating children is to tease out the differences in core gender identity from gender role behavior, and to help the child to understand those differences. It is not the role of the clinician to simply have a child say they are transgendered and accept that at face value, as the child is naïve and not yet capable of rationally evaluating their own thinking and feelings, yet that is precisely what many advocate now in gender clinics.

The appropriate people for cross-gender hormones and "gender affirming" surgery are adults who have a clear history of a core gender identity reversal from early childhood, and who are old enough to make informed decisions about their own care. They can understand informed consent. This population, from numerous studies, appears to be about .02-.025% of the population (far below what is now being seen presenting to "gender clinics"). People who exhibit a wide variety of gender role behavior but do not have a core gender identity conflict are inappropriate for transition and come to regret the decision if they do. See Appendix B for a discussion of the clinical and neurodevelopmental evidence for core gender identity, including the evidence from intersex studies.

Why is it so important to have a detailed history of core gender identity, gender role behavior and sexual orientation? It is because of two major issues. The first is medical. Putting a child through severe body changes as a result of hormones and surgery is traumatizing. Living one's adult life with a lack of fertility, likely medical complications from hormones and surgery (especially likely in female to male transsexuals) creates a likely lifetime of medical appointments and an ongoing attention to the medical aspects of an adolescent decision. The second major issue is social. Living one's life as an adult transsexual requires making a life-altering decision early on. In the case of a female to male transsexual, it is the decision to live one's life openly as a transman or to be closeted and simply pass as a male in society. If one thinks about it, they are very different lifestyles. People who live openly have the support of their community but are subject to the scrutiny and potential prejudice of others for the rest of their lives. Those who are closeted (usually only known as transsexual to their immediate family and life partner) are accepted

more in the (unaware) community but live with a secret which may change their status if anyone finds out. Prejudice against transsexual people is real. These reasons are why it is so important to determine what an individual's core gender identity is. This is done by looking at early body identification, reactions to beginnings of puberty, and also looking at identifying with the opposite sex at a very early age. This includes early feelings of alienation or differentness from one's own sex.

Who are the young people now stating that they are transgendered or non-binary flooding into gender clinics? These terms are a non-specific lumping of people with any degree of cross-gender feeling, mixing core gender identity, gender role identification and sexual orientation into a large political grouping. From a scientific perspective, it is a mistake, because many of them do not have core gender identity reversal, and for them hormonal and surgical interventions will lead to significant regret later, as core gender identity asserts itself. Clinics are beginning to see an increasing number of detransitioners, adolescents who transitioned in their early teens who regret it, as their sexuality and relation to their own body matures and new psychological insight is attained.

Mental Health Treatment of Chloe

At the age of 13, Chloe presented to the Kaiser-Permanente Mental Health Clinic in Manteca, California with a complaint of gender dysphoria. Here is the sequence of initial events leading to diagnosis:

1. On 6/13/17 in the pediatric clinic evaluation note, Chloe is referred to as male by Dr. Lourdes Humphrey Valdez. Parents report Chloe told them she had started to question gender when 9 years old. From the medical chart: "Pt mother states pt has expressed that he does not feel comfortable having a period, breasts, and hips. Pt states that he started to question his gender identity when he was 9 years old and in the past two years has been doing research and feels that he would be more comfortable as a male. Pt had his first menstrual cycle in October of 2016 but did not have another one until March/April of 2017. PT states he is attracted to males and relates more with them." It appears Chloe started researching transgender in 2015. A referral to Mental Health is made.
2. Chloe has a screening appointment on 6/21/17 with Matthew Esselstrom, MFT, who reports she states she is transgender and wants hormones.
3. On 8/11/17 she is seen by Lilit Asulyan, PsyD, a psychological assistant in the Mental Health Department of Kaiser-Permanente in Modesto, CA. In this appointment hormones and other transgender care are discussed with Chloe and her mother, but there is no evaluation of Chloe for her history of core gender identity or the development of her transgender feelings, even though there is evidence from the referral note from pediatrics that her interest in this started at age 9. It's also mentioned she came to this awareness from information on the internet, which she has done for two years without her parents knowledge. There is no indication that Dr. Asulyan has any experience in the area of gender identity evaluation with children or adolescents. Chloe is just over 13 years old.
4. On 9/22/17 Dr. Asulyan has scheduled a hormone evaluation appointment for Chloe for November. She had seen this patient once, and did not do a complete gender evaluation as noted above.
5. On Dr. Asulyan's note from 11/7/17: "GENDER HISTORY Around two to three years ago, pt started to question his gender. Pt stated that he felt more male than female. He stated that he did not share this with anyone at first. He stated that he kept this to himself for couple of years

and finally came out to his closest friends last year December. He stated that his friends were open and supportive. He stated that he told his parents June of 2017. He stated that both parents are supportive of it. Mom stated that while growing up, pt liked to wear dresses and pink clothes. Around second grade is when pt changed his style. This is when pt started to ask for and wear more "tomboy" looking clothes. Mom stated that she did not know and was surprised when pt first came out. She stated that it makes sense now and both parents are very supportive. Pt stated that his dysphoria is around his chest and hips, and his thin arms. He stated that he feels borderline disgusted when he thinks about it. He spoke with mom about getting a binder. Pt stated that he felt confused and anxious couple of years ago. He stated that whenever he looks at his body, it does not look the way he feels or sees himself. Mom stated that she had a difficult time in the beginning. She stated that she was worried about him, about how others will see him, accept him, judge him. She was more worried about his safety. She was afraid of pt becoming more depressed, bullied because of it. Mom stated that he wanted to make sure that it was not a phase that he was going through. Mom stated that she sees how uncomfortable he is, will be in his room, will wear loose fitting shirts. Mom stated that she knows that pt is hundred percent sure of who he is and mom feels comfortable consenting for procedures."

6. At the 11/7/17 visit Dr. Asulyan states that patient has "adequate information about the effects of the requested hormones or surgery, including irreversible effects, in order to be able to make an informed decision at this time?" Up to this time, Chloe has seen no physician for information about effects, surgery and irreversible effects. Dr. Asulyan is a psychological assistant and is not qualified to do so. Chloe has read about this treatment, but no questions about the effect of reading on the internet about encouragement to see self as transgender. But Chloe is specific about wanting the physical changes that hormones will bring. Dr. Asulyan recommends starting hormones. Patient is 13 years, 4 mos old. MST provider listed as Dr. Chang (MST stands for Multi-Specialty Transitions, a euphemism for transgender clinic). Dr. Asulyan states in note that patient has persistent, well-documented gender dysphoria, however the note above (#5 Gender History) is the total of Chloe's evaluation for gender dysphoria, including an evaluation of the history of core gender identity, gender role behavior and the source of her rather sudden discovery of gender dysphoria at age 11. There is no evidence Dr. Asulyan has any training in gender evaluation. In searching her licensure information, she was not licensed on her own until 2021, serving as a psychological assistant for 10 years. Her information with the Dept. of Psychology shows she has been licensed since 2021 and graduated from Alliant University in Los Angeles in 2011.
7. On 11/29/17 Chloe saw Francis Hoe, M.D. who discussed puberty blockers and hormones, but stated that Chloe needed to socially transition more and that he'd reconsider starting hormones when Chloe was 14. In the note by Dr. Asulyan on 12/15/17 she reports Chloe is unhappy that hormones were not immediately provided.
8. In December 2017 parents request a second opinion for puberty blockers. The speak by phone with Kristine Taylor, M.D. in Pediatric Endocrinology and discuss puberty blockers vs. hormones, since Chloe wants to go directly to hormones. As of Jan 2, 2018, Dr. Taylor orders Lupron (puberty blocker) for Chloe. In early February Dr. Taylor started Chloe on testosterone.

Throughout these visits and afterward, Chloe has constantly been evaluated for anxiety and depression. In May of 2020 she was started on an antidepressant by Dr. Singh in mental health.

There was a significant break in mental health visits shortly after hormones began until June 2019, when she was referred to Dr. Suzanne Watson (PhD) for evaluation for mastectomy. Dr. Watson is a gender specialist, but this was the first time Chloe had seen a gender specialist, a full two years after she was first seen, and 18 months after starting Lupron.

More chronology of visits:

1. On 7/8/19 Chloe had an appointment with Susanne Watson, PhD, for evaluation for mastectomy. She recounts Dr. Asulyan's note of two years before, and adds "Leo started having discomfort about his chest when he was 11 years old. It took him a couple of years to understand his discomfort as gender dysphoria." She reports that coming out as transgender led to an improvement in Chloe's sense of belonging and ease of interacting with friends at school. She states Chloe started testosterone in February of 2018. She reports that Chloe reports she has been very happy with the masculinization effects of the testosterone. Chloe reports being tired of having to bind her breasts. She makes note that Chloe is not interested in birthing a baby or breast feeding. She states Chloe has reported improved social anxiety since starting transition. While the initial evaluation in 2017 failed to adequately evaluate actual gender identity issues, as opposed to problems with gender role, given Chloe's emotional response to having been on testosterone for a year and 5 months, it's not surprising that Dr. Watson feels she is a good candidate. But in her note she makes an odd comment: "Leo has gender dysphoria specific to his chest that is having a negative impact on his emotional health and wellbeing." Does this mean that the gender dysphoria is conceived only in relationship to her chest? Body dysmorphia can be body part specific, but gender dysphoria is an expression of core gender identity, not a specific body part. It raises the question, which shows up nowhere so far in the medical record, of what are her thoughts and feelings about genital surgery eventually? How does she feel about having sex with female genitalia? Does she wish to have surgery to create male genitalia? Adult transsexuals (the only ones for whom surgery is appropriate) have an abhorrence of having others see them with "inappropriate" genitals for it reinforces in the sexual partner's perception that the person is female, not male. Dr. Watson approves Chloe for mastectomy.
2. Once chest surgery is approved, Chloe starts having bouts of depression and passive suicidal ideation.
3. On 8/27/19 Chloe sees La Tanya Takla (Psy.Asst.) She did an adequate job and referred for individual treatment, but no consideration of whether the current depression is evidence of apprehension toward upcoming chest surgery, or possibly recurrent depression (bipolar II?) This once again brings up what appears to be the use of screening questionnaires for making the diagnosis, rather than assisting the diagnosis. There is recurrence of this pattern of brief intense depressions followed by periods of cheerfulness for a number of years, but it seems not to be considered because the "bipolar questionnaire" was negative. There has been no comment in MH notes of evaluating the impact of cleft palate on how Chloe sees herself, especially given a recent revision of her original cleft palate repair? Mother clearly sees Chloe as depressed and anxious. Chloe also reports feelings of depression, but this is not seen as a possible contraindication for chest surgery.
4. On 9/18/19 Dr. Takla reports all symptoms have essentially resolved with no explanation why. The last appointment was three weeks ago and there is no idea what has changed. Since symptoms resolved, no further individual sessions are scheduled. This patient has gone from

having suicidal ideation to doing well in three weeks with no explanation of why there was improvement and no seeming exploration about what happened. This is an indication of depressive cycling, cause unknown.

5. There is then a brief delay in scheduling the surgery and Chloe is once again depressed with passive suicidal ideation. She recovers over several weeks, but there is no evidence the therapist considered that she is having bouts of depression about an upcoming surgery one would expect her to be quite eager for and happy. Throughout the end of 2019 Chloe is insistent that having the surgery will alleviate her depression. It is not considered that her recurrent depression might be an indication to delay the surgery and investigate. In December she is outed at school as female and transgender, having been living as male. There are no follow-up comments on how she has handled this.
6. In April 2020 the surgery is cancelled due to Covid. But she has bilateral mastectomy in June 2020.
7. By September she has had two more significant bouts of depression with passive suicidal ideation. The surgery has obviously not alleviated her depression. She is referred for Intensive Outpatient Program. She also starts to see an individual therapist, Susana Millan, LCSW. In late September there is a call between Mr. Brockman and Ms. Millan asking about legal name change for birth certificate and a letter required. She recommended contact with Dr. Watson, gender specialist. The reason this call is important is that it implies what the record shows, that all along, other than the evaluation done by Dr. Watson prior to surgery, this patient has not seen a gender specialist. This is a minor, who has now had major surgery and ongoing mental health problems, and no one has asked whether there is a problem involving the gender identity issue, partly because none of the ongoing clinicians are specialists in that area and know what to ask.
8. Chloe has also been out of school due to Covid, and this lack of access to her friends has not been helpful for her depression. She remains secretive toward parents, who found alcohol and vaping materials in her room. She has been on Adderall for ADHD from Dr. Singh, but stops it on her own.
9. In March 2021 Chloe requests to end therapy with Ms. Millan and requests an evaluation for ASD, which she's been reading about online. Her father is not in favor of her stopping and does not feel she has ASD.
10. On May 10, 2021 Chloe reports she believes she's made a mistake with hormones and surgery. Mrs. Brockman requests an appointment with a gender specialist as there is none in the Central Valley. This again verifies that all along she had been evaluated by non-specialists for gender issues. Chloe is again depressed.
11. On May 12 per Ms. Millan: Chloe states she wants to stay up late talking with social media friends. Patient wants cosmetic surgery to reverse "some things" and feels voice is too deep. From chart: "He would like it to be more "androgynous." He does not like that his jaw is "too strong looking," his shoulders are "too broad and big," and his hips are "too small." He would like facial hair electrolysis. Patient states he knows it will be a long process for him to achieve the imagines of his ideal self. He feels overwhelmed with his emotions and becomes frustrated." This is very precipitous. Is this bipolar II? Chloe then changes his view and says he does not regret transitioning. The social media friends are the detransitioners. Later in the day there is a phone call with mother who states Chloe wants to harvest eggs. A week later Chloe stops testosterone shots.

12. She seems to rapidly cycle from cheerfulness to depression during this time in May 2021.
13. On May 24, 2021 Dr. Watson: Spoke with Chloe and Chloe reported "Leo said, however, that his body shape was a "reverse triangle, the most unattractive shape for a female", before ever starting testosterone, and that he always felt uncomfortable with his body shape. Leo also expressed distress about facial bone structure, shoulders, neck, hips, "backside" and voice. Expressed desire to have FFS with tracheal shave, body contouring, voice surgery, vocal chord surgery, surgery to feminize his shoulders, and facial hair removal. Wants his hormone balance to get to normal female range as soon as possible and said he thinks not having enough sex hormone in his body has caused a worsening of his anxiety, depression and gender dysphoria." It is interesting that in a matter of a week Chloe has gone from wanting to transition with no clue to anyone else to the contrary, to not only wanting to reverse transition, but having a complete (and very unrealistic) plan for the reversal. Once again, is Chloe slightly manic, with Bipolar II? Dr. Watson also reports: Dr. Watson also reports "When I asked him about his desire to transition to male originally, he said he was "mised". He said he was always insecure about his masculine features and felt his only options was to transition. At first he felt "validated" by transition, but over time whenever he dressed in a masculine way, he felt uncomfortable. (Then he spoke about male clothing lacking color.) He said he had always been concerned about his own safety as a girl. Girls were stalked, assaulted and were not safe. "This terrified me. I still have major fear of it." Denied exposure to this kind of trauma but said fear was instilled in him by his parents who warned him of "stranger danger." These are all elements that might have come out in an initial gender evaluation with an experienced gender therapist.
14. Dr. Watson reports a plan in terms of gender dysphoria: "1. Referral for facial hair removal if parents are in agreement and after another meeting with Leo to discuss the permanent nature of this and the possibility of regret if his gender identity shifts again. 2. Leo has been referred for voice therapy. 3. Leo wants referral for FFS and tracheal shave. We will discuss this further and will include his parents. I have let Leo know that he would not be able to have this surgery before 18 years old. 4. After a year on his endogenous estrogen, referral to a plastic surgeon to discuss chest feminization surgery. Further recommendations: 1. Referral for autism evaluation 2. Possible referral to mental health clinician in the community who has expertise in autism as well as some familiarity with gender issues as this frequency of treatment and specialized treatment is not available at KP. I have a follow up appointment with Leo on 6/22/21 and will try to have a session with his parents as soon as possible to discuss my perceptions and recommendations." This is just as precipitous a decision as the original decision about approving gender transition by the original clinicians. Dr. Watson has clear evidence that the original issues were Chloe feeling inadequate with her body shape, not that she actually identified as being male ever. There is also now a precipitous decision to get an ASD evaluation because she has trouble making friends.
15. Sees Dr. Watson on 6/22/21 Chloe wants quick changes back to female which isn't going to happen per Dr. Watson's note. No one seems to ask that maybe her sleep problems are because she's up all night on the internet being influenced by either pro or con gender activists. No one has explored how much time she spends online and with whom.
16. On 6/23/21 Chloe is seen in IOP by Ms. Sarale: Her note: "Clinician validated pt in her pain, while challenging her to accept things now. Encouraged pt to embrace who she is with the more "masculine " personality that she feels she has and just be herself. Pt reports that she agrees.

- Clinician also talked with patient about putting boundaries on how much time is focused on detransition, to work on not letting it consume her life. Chloe states she agrees.
17. On 8/3/21 with Dr. Watson: Chloe shared her anger at her transition and stated she might file a lawsuit. Dr. Watson handled it supportively. Dr. Watson notes Chloe said she saw a gender therapist one time and was referred for testosterone (in 2017). There is no evidence that Dr. Asulyan had experience as a gender therapist. Chloe now thinks getting an ASD eval will make a big difference.
 18. Over the next several months Chloe has on and off depression. In September she gets Covid.
 19. In October 2021 Message from Laila Davis, PhD, ASD evaluator to set up morning appointment. Then there is an appointment with parents: In an interesting part of the evaluation, the parents shared that Chloe won't allow them to know anything about what she does online. This may explain some about their parenting style which seems very concerned and supportive but lacking in boundaries. Exemplified by another note in the evaluation " She does not go to sleep until about 2-3 AM and wakes up around 6:50AM. Parents estimate she gets about 4 hours of sleep per night. She will nap when she gets home from school for about 3 hours. She will stay up playing on her computer or phone. Parents are not sure who she is talking to online." She also notes behavioral rigidity that when younger Chloe would only wear very feminine clothing (not something one would see even in a closeted child with gender dysphoria). An appointment is set to evaluate Chloe. An interesting note within was that Chloe had very low APGAR scores when born and needed Narcan as mother states she was medicated too early in delivery and Chloe wasn't breathing. Possible etiology of ASD symptoms. Very thorough note by Dr. Davis In late October 2021 and late November Chloe has several hour visits with Dr. Davis for ASD evaluation, the latter one in person and behind two-way mirror with colleague. At the end of the meeting in Nov 2021 Dr. Davis submits a report: Dr. Davis: Comprehensive write up and description of ASD evaluation both from 10/26/21 and today. **Impression was that she is not on the ASD spectrum.** From the report: "While Chloe's early history is significant for several red flags for ASD, many of her current symptoms may be better accounted for by her existing diagnosis of Gender Dysphoria, ADHD-Primarily Inattentive Presentation, and Social Anxiety." There is an interesting note in the recommendations about setting guidelines with Chloe regarding use of social media, something the parents seem never to have done.
 20. In mid-November 2021 Chloe reports she has a boyfriend which is helping her depression.
 21. She has several more monthly visits with Ms. Millan, and then ends treatment in April 2022.

Discussion

While Chloe's experience was complex, as most cases are with children with multiple diagnoses, two major issues stand out for Chloe. The first is that the medical and mental health records show that there was not an evaluation for gender dysphoria that any experienced clinician would recognize as such. Essentially Chloe made her own diagnosis after two years of secretly interacting online at night with gender activists, who convinced her she was transgender. This was between ages 11 and 13. In answer to questions posed to Chloe about the beginnings of her gender dysphoria, she reported "I was not aware of any dysphoric feelings prior to using social media and learning about sexuality, gender identity and transitioning from it. I wanted to have a full figure and look womanly but at the same time I had mixed but mostly negative feelings about the attention I got from family, peers, etc when I started puberty at

9.” In answer to another question, she stated “from a young age I had a desire to at least have big breasts. I attribute this to early television, internet, social media, and porn exposure but also what I would overhear from conversations between my older teenage relatives including my sisters. Early in childhood, I picked up on the idea that having big boobs is a good, desirable, ideal trait in women, and that small breasts are forgettable and not desirable.”

One needs to keep in mind that these feelings were being formulated by an 11 year-old, and as such are not surprising. Experienced clinicians however are aware that female to male transsexuals do not have fantasies about having big breasts. In fact, as breasts start to develop, they find the experience abhorrent. Chloe was feeling inadequate because she didn’t realize that the size of one’s breasts at 12-13 years old is not indicative of adult size. Her feelings of inadequacy were mistaken by her, under the influence of social media, for being male as a fallback position. The sequence of thinking is understandable in a girl her age, but not indicative of gender dysphoria. A thorough evaluation by an experienced clinician would have detected:

1. No cross-gender feelings until age 11
2. Those feelings seem to have been generated by interacting with others online
3. Her feelings were fears of inadequacy as a female, not feelings of being male or identifying with having a male body.

Instead, her diagnosis was made by her, and rubber stamped by every clinician with whom she came in contact. In a review of the Kaiser-Permanente website, in the section for welcoming gender-questioning children and parents, it states that KP follows the guidelines established by the World Professional Association for Transgender health. Those guidelines state, regarding the clinicians doing evaluation:

5.1- We recommend health care professionals assessing transgender and gender diverse adults for physical treatments:

5.1.a- Are licensed by their statutory body and hold, at a minimum, a master’s degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.

5.1.b- For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.

5.1.c- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.

5.1.d- Are able to assess capacity to consent for treatment. 5.1.e- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.

5.1.f- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity

Chloe was initially evaluated by Lilit Asulyan, PsyD., a psychological assistant on 8/11/17 and 11/7/17. In the note of 8/11/17 there is no indication of exploration of the concept of core gender identity, or how Chloe’s came to change (under the influence of social media). There was no awareness of Chloe’s feelings of inadequacy driving her exploration online. As soon as Chloe stated her feelings of being

transgender, no further exploration was necessary. It was as if when a child says they're transgender, that's it; they are. In between the first two sessions, Dr. Asulyan had already requested an appointment for evaluation for hormones. In the 11/7/17 visit, Dr. Asulyan states the patient has "adequate information about the effects of the requested hormones or surgery, including irreversible effects, in order to be able to make an informed decision at this time." That is not possible. She had only seen Chloe once and had not done a gender evaluation, much less given Chloe or her parents adequate medication information, for which, as a psychologist, she was not qualified. In fact, there is no indication in the chart that Dr. Asulyan has experience as a gender specialist at all. In searching Dr. Asulyan's licensure information, she was not licensed on her own until 2021, serving as a psychological assistant for 10 years. Her information with the Dept. of Psychology shows she has been licensed since 2021 and graduated from Alliant University in Los Angeles in 2011.

The second major theme of Chloe's care is the lack of adequate informed consent. Deciding to medically and surgically alter one's body and live as the opposite sex is a major life decision. Why is a careful evaluation so important? Why is it so important to have a detailed history of core gender identity, gender role behavior and sexual orientation?

It is because of two major issues. The first is medical. Putting a child through severe body changes as a result of hormones and surgery is traumatizing and life-altering. Living one's adult life with a lack of fertility, likely medical complications of hormones and surgery (especially likely in female to male transsexuals) creates a likely lifetime of medical appointments and an ongoing attention to the medical consequences of an adolescent decision.

The second major issue is social. Living one's life as an adult transsexual requires making a life-altering decision early on. In the case of a female to male transsexual, it is the decision to live one's life openly as a transman or to be closeted and simply pass as a male in society. If one thinks about it, they are very different lifestyles. People who live openly have the support of their community, but are subject to scrutiny and potential prejudice of others for the rest of their lives. Those who are closeted (usually only known as transsexual to their immediate family and life partner) are accepted more in the community at large but live with a secret which may change their status if anyone finds out. Prejudice against transsexual people is real.

In order to have adequate informed consent, both child and parent need to address issues of:

1. Short and long term effects of puberty blockers and hormones
2. The likelihood of a decision later in adolescence that one is not transgendered after all (see Appendix A)
3. Effects on sexual performance and social aspects of sexual orientation (in Chloe's case, being a person with female genitalia who is attracted to males).
4. Surgical complications
5. Infertility and the inability of a 13 year-old to understand the implications of this.
6. The additional risks for someone with a history of depression.

Informed consent is not a one-time discussion, but especially for a child with a history of anxiety, depression and difficulty making and keeping friendships, waiting until adulthood is the appropriate approach to gender dysphoria, if it exists which in Chloe's case, was questionable. The time until then

can be spent discussing all of these issues in detail and allowing Chloe's brain and her social awareness to mature.

In the Review Journal of Sex & Marital therapy, 2022, Vol. 48, no. 7, 706–727 Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults, Stephen B. Levine, e. Abbruzzese and Julia w. Mason, they write:

“In November 2021, two-leaders of the World Professional Organization for Transgender Health (WPATH) warned the medical community that the “The mental health establishment is failing trans kids” (Anderson & Edwards-Leeper, 2021). Frequently, evaluations provided by gender clinicians may only ascertain the diagnosis of gender dysphoria (DSM-5) or its ICD-11 counterpart gender incongruence, and screen for conspicuous mental illness prior to recommending hormones and surgeries. These limited, abbreviated evaluations overlook, and as a result fail to address, the relevant issue of the forces that may have influenced the young person's current gender identity.”

It is this very issue of failing to address the forces influencing Chloe's decisions that led to an inadequate evaluation and informed consent and inappropriate, life-altering surgery.

Chloe

From the review of medical and mental health records, and viewing interviews Chloe has given recently to media, several issues become clear.

1. When Chloe started puberty, she was not advised by her parents about the bodily changes or the psychological issues involved. In children, the act of having the discussion is more important than the content, because it signals to the child that these are issues which can be discussed. Chloe had significant apprehensions about her bodily changes, feeling her breast growth was inadequate and didn't fit the image she already had about how she would develop. At age 11-13 she didn't fit her own image, but she didn't talk with any adult about this who could have told her about the changes to come. She had worries about what she perceived as broad shoulders and narrow hips, also physical elements that change significantly between ages 13 and 20. Her concern was that as a female, she wasn't measuring up to her own (adolescent) standard. A female to male transsexual does not feel “inadequate” as a female, but believes he is male and female body changes at all are reasons for fear and dread that they will continue.
2. Chloe should have been considered to have body dysmorphia, which in her case might have been alleviated with appropriate counseling about the normal time sequence of female development, and support that she could be a confident young woman however large her breasts were by age 20.
3. Chloe was very secretive about her exploration on social media about gender dysphoria. Although in numerous passages both she and her parents reported a positive relationship, this subject was hidden from them, which is not really surprising. But when she finally told them, it came out full-fledged. She wanted to transition medically to being a boy. Even then, the parents were kept in the dark about the two years of social media influence, and it appears they didn't ask. She was also fairly adamant with both her parents and her several subsequent clinicians that they should do as she asked.

4. There is a possibility that she was mis-diagnosed psychiatrically with recurrent depression, when it is possible that she has bipolar II disorder. Her fairly rapid sequences of depression with minor, everyday disappointments followed by rapid recovery with a “new plan” all worked out and insistent it be implemented are telling. This precipitousness of emotional swings needed to be explored, but was not noticed.
5. Throughout her pre-surgery and post-surgery periods, it has been reported she had sleep problems. As far as is known, her parents did not explore this or put together that she was up all night on social media.
6. She has continued to state that she is “on the spectrum,” when in fact the ASD evaluation was negative. She does in fact show some symptoms of autism, but not enough to warrant the diagnosis.
7. Chloe had pre-existing physical issues of a repaired cleft palate as a young child and an eventual secondary surgery while she was transitioning. There are no notes on how this may have affected her concept of feeling accepted or her perceptions of its impact on her in social situations as a child.
8. Chloe has been the victim of medical malpractice. How to deal with that objectively and working through the emotions is a challenge. One of the few people to approach her very therapeutically was Ms. Sarale in the IOP. She did supportive confrontation with Chloe about seeing how she also had a role in her problems, and how seeing herself as a victim may perpetuate her distress.

Mr. and Mrs. Brockman

All the records show the Brockman’s as concerned, conscientious parents. They are also rather passive and have significant difficulty setting limits with Chloe. As a result, Chloe has learned to push them to get what she wants. They seemed to have no limits on Chloe’s use of social media or have any idea what she was looking at. They report she refused to tell them, and they accepted that. She was staying up all night looking at transgender sites and then having problems sleeping. They also did not seem to question the qualifications of the people evaluating her or request even a verbal summary of the (non-existent) evaluation.

Kaiser-Permanente Mental Health

Chloe’s experience is a perfect example of what happens when social and political ideologies drive medical models of care instead of scientific evidence. When Chloe arrived in June 2017 and said she was transgender, the appropriate medical sequence of events was assumed. There was no gender evaluation. A simple request of “Tell me the story” would have unearthed that the origin of her gender dysphoria was feelings of inadequacy about her breast size and the shape of her shoulders and hips. It would have included knowing about how she had been influenced on social media, and what her contacts there had told her. That would have led to a discussion of what she had learned that was valid and what was unreasonable pressure from people who did not know her and likely had their own political interests at heart. There was no discussion of core gender identity and how she had felt being a girl up to age 11, prior to online pressure. There was no discussion about gender role behavior and the style of a boy or girl she saw herself as. There was no discussion about her awareness of her own sexuality. Since she sees herself as androphilic, a discussion of the experience of transmen in the gay male community would have been appropriate.

Instead, the moment she said she was transgender, it was assumed that no further evaluation was necessary. There is no evidence that the person she saw for her first evaluation (Dr. Asulyan) had any experience in evaluating transgender children or adolescents, and her clinical notes would indicate she didn't. She simply put Chloe on a medical conveyor belt, and before the next session had already made an inquiry about an appointment for Chloe for evaluation for puberty blockers and hormones. The first time Chloe saw a true gender specialist, Dr. Watson, was for the evaluation of appropriateness for mastectomy in July 2019. Dr. Watson saw the changes Chloe had made, and that she had been living as male. Dr. Watson did not know or question that the original diagnosis was made by Chloe, not a gender specialist following a careful evaluation.

At every step along the way, once the diagnosis was assumed, there was inadequate provision of informed consent. Chloe was a naïve 13 year old doing her own research. Dr. Asulyan's notes even state that informed consent had been done regarding hormones before Chloe had ever seen anyone qualified to do such informed consent. Competent informed consent might have spurred Chloe and her parents to reconsider the path she was on, or at least slow it down. There is no evidence in the record or on KP's website about their "Gender Affirming Care" that notes the evidence that an overwhelming majority of "transgender" children do not identify as transgender by the time they are 20. The parents obviously did not know this.

Chloe is now left with a masculinized voice, which may be able to be helped with training. She has had a mastectomy, a life-altering procedure, and has grown facial and body hair. All of this could have been avoided with an appropriate, in-depth evaluation by an experienced gender clinician. It also could have been avoided if the concept of "Gender Affirming Care" had not been translated into ignoring scientific evidence about the transience of childhood gender dysphoria. A watch and wait approach would not only have been most appropriate for Chloe but is valid for all adolescents with gender dysphoria. The small percent of adolescents who will eventually become adult transsexuals are in a difficult position during puberty due to the development of secondary sex characteristics of their biological sex, but careful clinical management can minimize the damage, and is what the medical community did for years prior to the recent change in philosophy to not ask questions and not do appropriate evaluation.

In summary this 13 year old decided her diagnosis after being pressured online by gender activists. She told a clinician her diagnosis and that initiated a medical process without intervening evaluation by a trained gender specialist. The fact that she also had significant cycling depression was not seen as an impediment to quickly moving to medical intervention. She and her parents were not provided informed consent. Signing an informed consent paper is the final step in a process of informing and discussion. It is a very different process for starting an adolescent on medical and surgical treatment for a likely transient diagnosis that will have major impact for the rest of the patient's life than it is for having one's tonsils removed. This is what happened. Would Kaiser-Permanente acknowledge that this is their model of care?

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Appendix A

From: Dr. James Cantor

Do trans- kids stay trans- when they grow up?

Following the closure of the CAMH Gender Identity Clinic for children, I have been receiving requests for what the science says. Do kids grow out of wanting to change sex, or does it continue when they are adults?

In total, there have been three large scale follow-up studies and a handful of smaller ones. I have listed all of them below, together with their results. (In the table, “cis-” means non-transsexual.) Despite the differences in country, culture, decade, and follow-up length and method, all the studies have come to a remarkably similar conclusion: Only very few trans- kids still want to transition by the time they are adults. Instead, they generally turn out to be regular gay or lesbian folks. The exact number varies by study, but roughly 60–90% of trans- kids turn out no longer to be trans by adulthood.

Count Group	Study
2/16gay 4/16trans-/crossdress 10/16straight/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
2/16trans- 2/16uncertain 12/16gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
0/5trans- 5/5gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
2/45trans-/crossdress 10/45uncertain 33/45gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.

1/10trans- 2/10gay 3/10uncertain 4/10straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
1/44trans- 43/44cis-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i>. New Haven, CT: Yale University Press.
0/8trans- 8/8cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? <i>Medical Journal of Australia</i> , 146, 565–569.
21/54trans- 33/54cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 47, 1413–1423.
3/25trans- 6/25lesbian/bi- 16/25straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i>, 44, 34–45.
17/139trans- 122/139cis-	Singh, D. (2012). <i>A follow-up study of boys with gender identity disorder</i>. Unpublished doctoral dissertation, University of Toronto.
47/127trans- 80/127cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 52, 582–590.

(I have bolded the more well-known studies-Robin Dea)

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Appendix B

The concepts of core gender identity start with understanding fetal development. While the physiological processes are well documented, the exact outcomes for specific clinical presentations are not possible to prove conclusively, but direct evidence and indirect evidence indicate the neurodevelopmental nature of gender identity.

Fetal Development

The basic fetal development per C.E. Roselli:

“It is accepted dogma that testes develop from the embryonic gonad under the influence of a cascade of genes that begins with the expression of the sex-determining gene *SRY* on the Y chromosome.^{4,5} Before this time, the embryonic gonad is “indifferent”, meaning that it has the potential to develop into either a testis or an ovary. Likewise, the early embryo has 2 systems of ducts associated with urogenital differentiation, Wolffian and Müllerian ducts, which are capable of developing into the male and female tubular reproductive tracts, respectively. Once the testes develop, they begin producing 2 hormones, testosterone and anti-Müllerian hormone (AMH). In humans, this occurs at about 7–8 weeks of gestation. Testosterone and one of its derivatives, dihydrotestosterone, induce the differentiation of other organs in the male reproductive system, whereas AMH causes the degeneration of the Müllerian ducts. Female ovaries develop under the influence of a competing set of genes that are influenced by expression of *DAX1* on the X chromosome and act antagonistically to *SRY*. The female reproductive tract in the embryo develops in the absence of androgens and later matures under the influence hormones produced by the ovary, in particular estradiol.

“In humans, the elevation in testosterone occurs between months 2 and 6 of pregnancy and then again from 1 to 3 months postnatally.⁶ During these times, testosterone levels in the circulation are much higher in males than in females. These fetal and neonatal peaks of testosterone, together with functional steroid receptor activity, are considered to program the male brain both phenotypically and neurologically.

“In humans, the genitals differentiate in the first trimester of pregnancy, whereas brain differentiation is considered to start in the second trimester. Usually, the processes are coordinated and the sex of the genitals and brain correspond. However, it is hypothetically possible that, in rare cases, these events could be influenced independently of each other and result in people who identify with a gender different from their physical sex.”

Neuroanatomy

Roselli rightly uses the word “hypothetically.” Other papers published over the years give an interesting picture of differences in brain structure in transsexuals. A review by Sarah J. Lewis stated:

“The first study of its kind was conducted by Zhou et al (1995)^[1]. The study found sex atypical differences in the stria terminalis of the brain stem when studying transgender subjects.

“A follow up study by Kruijver et al (2000)^[2] confirmed the findings and provided greater insight.

“The central subdivision of the bed nucleus of the stria terminalis (BSTc) is sexually dimorphic. On average, the BSTc is twice as large in men as in women and contains twice the number of somatostatin neurons. These numbers do not appear to be influenced by sexual orientation or hormone replacement therapy - and both were controlled for by Zhou and Kruijver.

“A paper by Chung et al (2000)^[3] studied how the volume of the BSTc varied with age in both male and female subjects. They found that the dimorphism was only prevalent in adulthood. Suggesting that the differences found by Zhou and Kruijver are not a cause of gender dysphoria but rather a result.”

In the hypothalamus Sarah Lewis found the following studies:

“Berglund et al (2008)^[7] demonstrated that brain activation in trans-women was similar to female controls (and dissimilar to male controls). The researchers' conclusion was, that in terms of pheromone activation, trans-women occupy an intermediate position with predominantly female features. The paper further speculates that the cause for the observed differences may lie in the structure of the hypothalamus.

Garcia-Falgueras and Swaab (2008)^[8] investigated the hypothalamic uncinat nucleus, which is composed of two subnuclei, namely interstitial nucleus of the anterior hypothalamus (INAH) 3 and 4. They showed for the first time that INAH3 volume and number of neurons of trans-women is similar to that of control females. The study also included analysis of a single trans-man who also had a INAH3 volume and number of neurons within the male control range.

Consistent with the initial studies by Roselli, these findings support the idea that early fetal development creates clear structural changes between males and females, and that there are findings in both male to female and female to male transsexuals that are more similar to the findings of the sex to which they identify.

Clinical Correlates

Exploring other medical conditions adds interesting insights into the innate nature of gender identity. Complete Androgen Insensitivity Syndrome is characterized by a defective gene which codes for the ability of cells to recognize and attach testosterone in any of its forms, specifically testosterone and dihydrotestosterone. These children are XY chromosomally, but are born with female external genitalia, a blind pouch for a vagina, and undescended testes. When one considers that their cells are completely immune to the effects of testosterone, that they appear female is not surprising. What is also interesting is that they uniformly have a female gender identity (one possible known case in history of a male gender identity). How is it that all of these genetic males have a female gender identity? It is because of the lack of any testosterone effect during fetal development.

5 alpha-reductase deficiency was studied in a cohort of children born in the Dominican Republic in one extended family, and was traced to a genetic defect in a single female ancestor. These XY children were born with either female genitalia or slightly masculinized female genitalia and were raised as female due

to a defect in the conversion of precursors to fetal testosterone. However, throughout childhood they were known for having more overtly male behavior and some expressed overt cross-gender feelings. When they went through puberty, and the adult form of testosterone started to be produced, they started to go through male puberty. In normal females, such an experience would be very traumatizing, but in these children, it brought about a sense of relief and confession that most of them had always “felt” male. They started to live as males. They did not have an absolute absence of dihydrotestosterone, just a relatively minimal amount. Their gender identity was male in spite of being raised as female.

In the scientific community studying transgender issues, the story of David Reimer is well known, as reported by John Colapinto in his book, [As Nature Made Him](#). David was one of two identical male twins. Due to a minor structural issue with the foreskin, it was decided by the parents to have both boys circumcised. There was an accident with the electrocautery machine, and David’s penis was burned off. The boys were taken eventually to see Dr. John Money at Johns Hopkins, and he embarked on a process to prove his theory that gender identity was a social construct. He intended to show that if raised as a girl, David, now Brenda, would grow to have a normal female gender identity. Through psychological abuse and falsification of records and research papers, he promoted the case as a success. But at age 14, when Brenda discovered she had been born male, she shared that she had always felt male. David took that name and lived as a male. He shared that he had always had a male gender identity. The case showed both the depravity of Dr. Money, but also the inflexibility of biologically based core gender identity.

Analysis

The scientific conclusion one can draw is that there are elements in early fetal development that program the brain for gender identity. From an evolutionary biology perspective, this makes perfect sense, as it aids the species in generating progeny. Both structural brain studies of transsexual individuals and clinical observations of the disorders of sex development help clinicians to understand the necessity of exploring core gender identity with anyone entering treatment as a transgender person.

COURT OF THE STATE OF CALIFORNIA SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH		FOR COURT USE ONLY
TITLE OF CASE (Abbreviated) Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.		
ATTORNEY(S) NAME AND ADDRESS Charles S. LiMandri, Esq; Paul M. Jonna, Esq. Robert E. Weisenburger, Esq. LiMANDRI & JONNA LLP P.O. Box 9120 Rancho Santa Fe, California 92067 Tele: (858) 759-9930; Fax: (858) 759-9938		
ATTORNEY(S) FOR: Plaintiff Chloe E. Brockman	Dept. 11B	CASE NO.: STK-CV-UMM-2023-0001612

PROOF OF SERVICE

I, Rebecca M. Oakley, declare that: I am over the age of 18 years and not a party to the action; I am employed in, or am a resident of the County of San Diego, California, and my business address is P.O. Box 9120, Rancho Santa Fe, CA 92067, Telephone number (858) 759-9930; Facsimile number (858) 759-9938. I further declare that I served the following document(s) on the parties in this action:

Motion for Leave to Amend

1. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF MOTION AND MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
2. **PLAINTIFF CHLOE E. BROCKMAN’S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
3. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF LODGMENT OF CONFIDENTIALLY MARKED DOCUMENTS IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
4. **DECLARATION OF CHLOE E. BROCKMAN;**
5. **DECLARATION OF CHARLES S. LIMANDRI IN SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN’S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
6. **DECLARATION OF JOCELYN T. BROCKMAN;**
7. **DECLARATION OF ROBIN A. DEA, M.D.;**
8. **DECLARATION OF NATHAN SZAJNBERG, M.D.;**
9. **DECLARATION OF MICHAEL LAIDLAW, M.D.;**
10. **DECLARATION OF JOHN PERROTTI, M.D.;**
11. **DECLARATION OF STEPHEN B. LEVINE, M.D.;**
12. **DECLARATION OF TIM CROSBY, LMFT;**
13. **DECLARATION OF KAYLA LOVDAHL;**
14. **DECLARATION OF ELISABETH “BETH” BOURNE;**
15. **DECLARATION OF LAUREN WOHL-SANCHEZ; and**
16. **[Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN’S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES.**

Motion to Seal

1. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF MOTION AND MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND**

COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;

- 2. PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES; and**
- 3. [Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES**

by one or more of the following methods of service to:

****SEE ATTACHED SERVICE LIST**

 (BY U.S. MAIL) I caused such document(s) to be sealed in envelopes, and with the correct postage thereon fully prepaid, either deposited in the United States Postal Service or placed for collection and mailing following ordinary business practices.

 X **(BY E-MAIL/ELECTRONIC MAIL)** I caused a copy of the foregoing document(s) to be sent to the persons at the e-mail addresses listed above, this date via internet/electronic mail.

 X **(BY ELECTRONIC FILING/SERVICE)** I caused such document(s) to be Electronically Filed and/or Service through OneLegal.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 18, 2024



Rebecca M. Oakley

COURT OF THE STATE OF CALIFORNIA
SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH

Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.
CASE NO.: STK-CV-UMM-2023-0001612

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