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**Admitted Pro Hac Vice*

19 Attorneys for Plaintiff
20 CHLOE E. BROCKMAN

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 COLE,
24 an individual

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

25 Plaintiff,

**DECLARATION OF NATHAN
SZAJNBERG, M.D.**

26 v.

27 KAISER FOUNDATION HOSPITALS, INC.,
28 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,

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

Defendants.

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

DECLARATIN OF NATHAN SZAJNBERG, M.D.

I, Nathan Szajnberg, 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 Preliminary Psychiatric Assessment of Chloe Brockman.

I declare until penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on Feb 7, 2024, at Paso Robles, CA.

Dated: Feb 7, 2024.

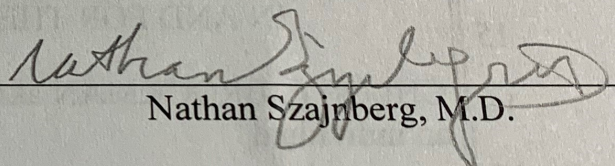

Nathan Szajnberg, M.D.

EXHIBIT 1

Nathan Moses Szajnberg, M.D.
3941 Duncan Place
Palo Alto, Ca. 94306
nmoshe@gmail.com
650 272 8555

Education/Training

University of Chicago, B.A., Biology	1974
University of Chicago, M.D.	1974
University of Chicago, Pediatrics Resident,	1974-5
Michael Reese Hospital, Residency in General Psychiatry	1975-7
Michael Reese Hospital, Residency in Child & Adol. Psychiatry	1977-9
Graduate, St. Louis Psychoanalytic Institute	1999

Academic Appointments:

Assistant Prof. of Psychiatry, Cornell University Medical College	1981-5
Assistant Prof. of Psychiatry, University of Connecticut	1985-7
Associate Clinical Prof. University of Connecticut	1987-91
Associate Professor, Medical College of Wisconsin	1992-5
Clinical Professor II, University of California, San Francisco	1996-05
Visiting Scholar, Freud Center, The Hebrew University	2007-8
Sigmund Freud Professor, Hebrew University	2008-10
Visiting Professor, Columbia University	2010-13
Private Practice	1979-

Editorial Experience

- Editorial Board, Psychoanalytic Psychology (under Bert Cohler) 1994
- Chair, Scientific Committee, New York Psychoanalytic Institute 2010-11
- Managing Editor, InternationalPsychoanalysis.net (Ed., A. Richards, MD)
2011-14
- Editorial Board, International Journal of Controversial Discussions 2020-

Honors and Awards: (selections)

1. NIMH, Research Fellow: Adolescence 1977-8
2. NIMH, Faculty Career Development Grant: Infancy (Mentors: Dan Stern, Sally Provence)
1983-4
3. Int'l Psychoanalytic Association, RAB 1998-2000; 2003-4
4. Ticho Lecturer 2012
5. Wallerstein Research Fellow in Psychoanalysis, SFPI 2005 -
2016
6. Stanford U./Kalanithi Short Story Award (2d place) 2019

PUBLICATIONS

1. Szajnberg, N. and Diamond, S. (1980). Migraine Headache, Biofeedback and New Symptom Formation. *Headache*, 20:1, 29-31.

- 2. Szajnberg, N. (1983). Visual Maturation and Part-Object Mental Representations in the First Half-Year of Life. *Inf. Ment. Health JI.*, 4:2, 83-94.**
3. Szajnberg, N. (1985). Staff Countertransference in the Therapeutic Milieu: Creating an Average Expectable Environment. *Br. J. of Med. Psychol*, 58:331-6.
- 4. Szajnberg, N. (1986). An Empty Memory: A Defect in Evocative Memory Treated by Psychotherapy. *Dynamic Psychotherapy*, 3:2, 171-181.**
5. Szajnberg, N. (1986). Übertragung, Metaphor and Transference in Psychoanalytic Psychotherapy. *Int. J. of Psychoanalytic Psychotherapy*, 11:53-69.
6. Szajnberg, N. (1986). Medical Students' Attitudes Towards Child Psychiatry: The Impact of a Third-Year Required Rotation. *J. of Psychiatric Ed.*, 10:1, 5-14.
- 7. Szajnberg, N., Ward, M.J., Kessler, D., and Krauss. A. (1987). Low Birth-Weight Premature Infants: Preventive Intervention and Maternal Attitude. *Child Psychiatry and Human Development*. 17:3, 152-165.**
8. Szajnberg, N. (1987). The Milieu Therapist: Toward a Theory of Action. *Residential Treatment for Children and Youth*, 5:2, 51-57.
- 9. Szajnberg, N. and Weiner, A. (1988). Children's Conceptualization of Their Own Psychiatric Illness and Hospitalization. *Child Psychiatry and Human Dev.*, 20:2, 87-97.**
- 10. Szajnberg, N., Skrinjaric, J., and Moore, A. (1989). Affect Attunement, Attachment, Temperament and Zygoty: A Twin Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 28:2, 249-253.**
- 11. Szajnberg, N. (1989). The Developmental Continuum from Secrecy to Privacy in a Psychodynamic Milieu. *Residential Treatment for Children and Youth*, 6:2, 9-27.**

- 12. Szajnberg, N. and Skrinjaric, J. (1989). Family Discord in Childhood Cancer. Arh. zast, majke and djeteta, 5-12.**
13. Szajnberg, N. (1989). Inpatient Child and Adolescent Psychiatry Training: A Panel Report. Soc. Professors of Child and Adol. Psychiatry Newsletter, 1-3.
14. Szajnberg, N., Zalnairitis, E., Altman, Al, Weisman, S., Andrulonis, P. (1989). Anorexia Nervosa in a Child with Acute Lymphocytic Leukemia in Remission. Clinical Pediatrics, 28:12, 561-567.
15. Szajnberg, N. (1992). Psychoanalysis as an Extension of Autobiographical Genre: Poetry and Truth, Fiction and Reality. Int. Journal of Psychoanalysis 19:3, 375-87.
- 16. Szajnberg, N., Krall, V., Davis, P., Treem, W., and Hyams, J. (1993). Psychopathology and Relationship Measures in Children with Inflammatory Bowel Disease and Their Parents. Child Psychiatry and Human Development 23:3, 215-232.**
- 17. Szajnberg, N. (1993). Recovery of a Repressed Traumatic Memory and Subsequent Representational Shift in an Adolescent's Analysis. JAPA 41:3, 711-27.**
- 18. Rusakow, L., Gershan, W., Bulto, M., and Szajnberg, N. (1993). Munchausen's Syndrome Presenting as Cystic Fibrosis with Hemoptysis. Ped. Pulmonology, 16:326-9.**
- 19. Szajnberg, N. (1994). Mobius Syndrome: Alternatives in Affective Communication. Developmental Medicine and Child Neurology, 36, 459-462.**
20. Szajnberg, N. (1994). Bruno Bettelheim: Culture in Man, Man in Culture and a Language for Both. Psychoanalytic Review, 81(3): 491-507.
- 21. Skrinjaric, J., Szajnberg, N., Vidovic, V., DeZan, D. (1994). Mothers' Perceptions of Infant Affect in a Croatian Sample: The IFEEL Pictures. Inf. Ment. H. J. 15(4):328-35.**

22. Szajnberg, N. and Altman, A. (1994). Consultation-Liaison and General Systems Theory. International Pediatrics, Vol. 4:39-45.

23. Szajnberg, N., Altman, A., Weisman, S., and Quinn, J. (1995). Physician/Nurse Attitudes and Treatment Adherence/Compliance in Children with Cancer: A Pilot Study and New Instrument. Psycho-Oncology, Vol. 4:47-53.

24. Krall, V., Szajnberg, N., Hyams, J., Treem, W. and Davis, P. (1995). Projective Personality Tests of Children with Inflammatory Bowel Disease. Perceptual and Motor Skills, 80: 1341-2.

25. Kozaric-Kovacic, D., Folnegovic-Smalc, V., Skrinjaric, J., Szajnberg, N., and Marusic, A. (1995). Rape, Torture, and Traumatization of Bosnian and Croatian Women: Psychological Sequelae. Am. J. Orthopsychiatry, 65(3):428-33.

26. Szajnberg, N. and Weiner, A. (1996). Children's Concepts of Psychiatric Treatment and Cure. Child Psychiatry and Human Development. 26: 4, 247-254

27. Szajnberg, N. (1996). Towards a Conceptual Alliance about Therapeutic Alliance: a Voyage Through the Inferno, J. Am Acad. of Psa. 24:1, 95-113.

28. Szajnberg, N., Moilanen, I., Kanerva, A., Tolf, B. (1996). Munchausen-by-proxy syndrome: Countertransference as a diagnostic tool. Bull. Menninger Clin. v. 60, 2, 229-37.

29. Szajnberg, N. and Crittenden, C. (1997). The Transference Refracted Through the Lens of Attachment. J. Am Acad. of Psa. 25: 3, 409-438

30. Massie, H. and Szajnberg, N.M. (1997). The Ontogeny of a Fetish from Birth to Age 30 and Memory Processes: A Research Case Report From a Prospective Longitudinal Study. Int. J. of Psychoanalysis. 78: 755-771.

31. Szajnberg, N. (1997). "The Aesthetic Aspects of Psychoanalysis." J. Am. Acad. Psa. 25 (2), 189-210.

- 32. Hiltunen, P. Moilanen, I., Szajnberg, N., Gardner, N. (1999). The IFEEL Pictures: Transcultural aspects of importing a new method. Nord. J. Psychiatry, 53, N. 3, 231-5.**
- 33. Massie, H. and Szajnberg, N. (2000). The Evolution of Six Hyperactive Children from Birth to Age Thirty: A Psychoanalytic Study of Troubled Attachment and Transformation of Symptoms." Perspectives Psychiatriques, 2000.**
- 34. Massie H. and Szajnberg N. (2002) Relationship Between Mothering in Infancy, Childhood Experience and Adult Mental Health. Int. J. of Psychoanal. 83,1; 35-55.**
- 35. Hiltunen, P., Jokelainen, J., Ebeling, H., Szajnberg, N., Moilanen, I. (2004) "Seasonal variation in postnatal depression." J. of Affective Dis. 78, # 2, 111-8.**
- 36. Szajnberg, N.M. and Massie, H. (2003). Transition to Young Adulthood: A Prospective Study. Int. J. Psychoanal. 84, 6, 1569-1586.**
- 37. Massie, H., Szajnberg, NM. (2006). "My Life Is a Longing: Child Abuse and Its Adult Sequelae from Birth to Age 30." Int. J. Psychoanal., 87: 471-96.**
- 38. Szajnberg, NM, Elliot Wilson, M, Beuachaine, TP, Waters, E. (in press). Mothers of Children with Inflammatory Bowel Disease: Attachment Classifications and Patterns of Psychopathology" Isr. J. Psychiatry**
- 39. Szajnberg, NM. (2010). Dante's *Commedia*: Its Contribution to a Psychoanalytic Sense of What is Human and Precursors of Psychoanalytic Technique. Int. J. Psycho-Anal. 91: 183-197.**
- 40. Szajnberg, NM. (2010). Dreaming and Development: Early, Mid and Late Phase Shifts in Associative and Interpretive Processes. Psychoanal. Rev., 97(4):633-656.**
- 41. Szajnberg, N. Goldenberg, A. Harari, U. (2010) Early Trauma, Later Outcome: Results from Longitudinal Studies and Clinical**

Observations. In: Editors, Vermetten and Lanius, "The Impact of Early Life Trauma on Health and Disease". Cambridge University Press.

42. Szajnberg, N. M. (2011). Clarity and Ambiguity in Psychoanalytic Practice. Bulletin of the Menninger Clinic, 75, No 1; p. 1-20.

43. Szajnberg, N (2012). Emotions Concealed and Revealed: Ekman's Contribution to a Common Ground in Psychoanalysis. International Psychoanalysis.

44. Szajnberg, N. (2012). Analyst's Countermovements in Child Treatment. International Psychoanalysis.

45. Szajnberg, N.M. (2012). Zombies, Vampires, Werewolves: An Adolescent's Developmental System for the Undead and Their Ambivalent Dependence on the Living, and Technical Implications. Psychoanal. Rev., 99:897-910.

46. Szajnberg, N.M. (2013). Caravaggio Four Centuries Later: Psychoanalytic Portraits of Ambivalence and Ambiguity. J. Amer. Psychoanal. Assn., 61:311-331.

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48. Szajnberg, N. (2018). Lives Felt—Or Not: Reminiscences of a Viennese Psychoanalyst. By Richard F. Sterba. Detroit: Wayne State University Press, 1982, 184 pp., \$39.95 hardcover.. J. Amer. Psychoanal. Assn., 66(3):595-599.

49. Szajnberg, N. (2018) Book Review: Psychoanalysis: Perspectives on Thought Collectives. More Selected Papers by Arnold Richards, Volume 2, edited by Arthur Lynch, IPBooks, 2017, 382 pp.. Psychodyn. Psych., 46(4):608-613.

50. Wu, Y. And Szajnberg, N.M. , E. T. Kenny (Fall 2020) "Confusion of Tongues: Mistranslation of Psychoanalytic Terms from German through English to Mandarin" International Journal of Psychoanalysis.

51. Wu, Y. And Szajnberg, NM (Summer 2020) “As-If Countertransference: A Chinese Experience” *International Journal of Psychoanalytic Controversies*.

52. Szajnberg, N (accepted for publication) “Saul Bellow: From a One-Person to a Two-Person Representation: a Lifetime’s Evolution.”

53. Szajnberg, N. (Accepted for Publication). “Working Juvenile Jail: “What’s an Analyst Like You Doing In a Place Like This?” *Dynamic Psychiatry*

54. Szajnberg, N. (2021) Book Review: *THE HANDBOOK OF PSYCHOANALYTIC HOLOCAUST STUDIES: INTERNATIONAL PERSPECTIVES*. Edited by *Ira Brenner*. *JAPA*, [Volume 69, Issue 3](#) (New York: Routledge, 2020, xx + 246 pp.,)

55. Wu, Y. And Szajnberg, N. (2023) Book Review: *The Invention of Madness: State Society and the Insane in Modern China* by Emily Baum *JAPA* Summer 2023. U. Of Chicago Press. 2018.

BOOKS

Szajnberg, N. (Ed.) 1992 *Educating the Emotions: Bruno Bettelheim and Psychoanalytic Development*, Plenum: New York.

Massie, H. and Szajnberg, N.M. (2008): *Lives Across Time/Growing Up: a Thirty Year Prospective Study*. Karnac.

Szajnberg, N. 2011. *Reluctant Warriors: Israelis Suspended Between Rome and Jerusalem*. IPBooks.

Szajnberg, N. 2013 *Sheba and Solomon’s Return: Ethiopian Children in Israel*. Createspace.

Szajnberg, N. 2018. *JerusaLand: An Insignificant Death* (Amazon)

Szajnberg, N. 2018 *Jacob and Joseph, Judaism’s Architects and Birth of the Ego Ideal*. Cambridge Scholars.

Szajnberg, N. M. 2019 *Breathless: Unspoken Words After Death*. Amazon

Szajnberg, N. M. 2023. *Psychic Mimesis: Inner Life from Bible and Homer to Now*. Lexington.

Szajnberg, N. M. 2023. *The Secret Symmetry of Maimonides and Freud*. Routledge.

Chapters and Reviews (Selections)

1. Szajnberg, N. (1985). The Growing Edge of Development: The Developmental Process and Its Implications for Psychoanalytic Psychotherapy. In: Eds. G. Lubin and N.K. Poulsen, *Piagetian Theory and Its Implications for Mental Health*, California: USC Press, 76-77.
2. Szajnberg, N. (1991). Play Therapy Primer: Therapeutic Approaches to Children with Emotional Problems, by V. Krall. *Journal of American Academy of Child and Adolescent Psychiatry*, 30:5, p 857.
3. Szajnberg, N. and Skrinjaric, J. (1993). Perceptions of Infant Affect in Premature Mothers: The I-FEEL Assessment. In: *The I-FEEL Pictures: A New Instrument for Interpreting Emotions*, eds. R. Emde, J. Osofsky, P. Butterfield. National Center for Clinical Infant Programs, Madison, CA: International Universities Press..
4. Szajnberg, N. (1993). The IFEEL Pictures as a Projective Instrument: Pre- and Full-Term Mothers. In: *The IFEEL Pictures: A New Instrument for Interpreting Emotions* Eds. R. Emde, J. Osofsky, P. Butterfield. National Center for Clinical and Infant Programs, Madison, CA: International Universities Press.
5. Szajnberg, N. (1993). Recruitment of Residents into Psychiatry: Implications for Child and Adolescent Psychiatry. *Society of Professors of Child and Adolescent Psychiatry Newsletter*, March, Vol. 2, 7-8.
6. Krener, P., Szajnberg, N. (1993). *Society of Professors of Child and Adolescent Psychiatry: Program Summary of the Annual Meeting*, March 26-29, 1993. Mutual Aid--Planning for the Future in a Time of Transition.

Society of Professors of Child and Adolescent Psychiatry Newsletter, October , Vol. 2, 2-7.

7. Radford, P. and Szajnberg, N. (1995). Understanding Trauma in Childhood and Adolescence: What Do We Mean When We Say That A Child Has Been Traumatized? Presentation at the biennial meeting of the International Association for Child and Adolescent Psychiatry and Allied Professions and co-sponsored by the Association for Child Analysis. Association for Child Psychoanalysis Newsletter, June, 1995: 22-24.

8. Waters, E, Crowell, J., and Szajnberg, N. (1995). Implications of Attachment Theory for Infants and Preschoolers Who Require Hospitalization. In JL Marsh and Rebecca Eder. Craniofacial Anomalies: Psychological Perspectives.

9. Szajnberg, N.M. (2001). Political Theory and the Psychology of the Unconscious: Paul Roazen. London: Open Gate Press, 2000. 202 pp.. Psychoanal Q., 70(4):918-923.

10.. Szajnberg, N. (2003). The Development of Anorexia Nervosa: The Hunger Artists. By Sylvia Brody. Madison, Ct.: I.U.P. 2002, 255 pp. J. Amer. Psychoanal. Assn., 51: 704-9.

11. [Szajnberg, N. \(2004\). Healing the Soul in the Age of the Brain, by Elio Frattaroli, Viking Press, New York, 2001, 454 pp., \\$25.95.. J. Amer. Acad. Psychoanal., 32\(4\):709-710.](#)

12. Szajnberg, N. (2004). Nathan Szajnberg Responds. J. Amer. Psychoanal. Assn., 52(4):1301-1303

13. [Szajnberg, N. \(2004\). Response to Dr Fleming. Int. J. Psycho-Anal., 85\(2\):528-529.](#)

14. Szajnberg, N. M. (1998). Symbolization: Proposing a Developmental Paradigm for a New Psychoanalytic Theory of the Mind. By Anna Aragno. J. Amer Academy of Child & Adolescent Psychiatry: Vol. 37 – Iss.11 - p 122-3.

15. Massie, H. and Szajnberg, N. (2004) “How Could They Do That?” Parental aggression: its impact on children’s adult mental health, its link to

understanding social violence.” In J. Morgan, Ed. *Focus on Aggression Research*. NY: Nova Science Publishers, pp. 15-39.

16. Szajnberg, N. (2005). Impact of Narcissism: The Errant Therapist on a Chaotic Quest, by Peter Giovacchini, Jason Aronson, 2000, 324 pp., \$40.. J. Amer. Acad. Psychoanal., 33(4):761-763.

17. [Szajnberg, N. \(2005\). THE INTERNAL WORLD AND ATTACHMENT. By Geoff Goodman, Ph.D. Hillsdale, NY: Analytic Press, 2002. 339 pp.. Psychoanal Q., 74\(3\):896-899.](#)

18. Szajnberg, N. (2007). *Protecting the Self: Defense Mechanisms in Action*, Phebe Cramer, Guilford, 2006, In: Int. J. Psa.

19. Szajnberg, N. (2007). Letters to The Editors: On: Attachment Theory and Psychoanalysis. Int. J. Psycho-Anal., 88(1):240-241.

20. [Szajnberg, N. \(2008\). *Protecting the Self: Defense Mechanisms in Action* by Phebe Cramer Guilford Press, New York, 2006: 384 pp; \\$45. Int. J. Psycho-Anal., 89\(1\):202-204.](#)

21. Szajnberg, N. (2008). The, Future of Prejudice: Psychoanalysis and the Prevention of Prejudice. Edited by Henri Parens, Afaf Mahfouz, Stuart Twemlow, and David Scharff. New York: Guilford Press, 2005, 256 pp., \$70.00.. J. Amer. Psychoanal. Assn., 56(2):644-649.

22. Szajnberg, N. (2010). On: The Possibly Narcissistic Difficulties Among Scientific Cultures: A Response to Marty's 1952 Key Paper. Int. J. Psycho-Anal., 91(6):1523-1524.21.

23. Szajnberg, N. (2011). On: Attachment and Psychoanalysis; Working Models and Part-Object Transferences. Int. J. Psycho-Anal., 92(2):471-472.

24. Szajnberg, N. (2008). *The Future of Prejudice*. Parens, Mahfouz, Twemlow and Sharff. Aronson (2006). In: JAPA.

25., Szajnberg, N. and Goldenberg, A. (2009). The Texture of Treatment and Endings and Beginnings, H. Schlesinger, 2003, 2005). Sichot (In Hebrew)

24. Szajnberg, N. and Segal, K. 2010. *The Struggle Against Mourning.*, Ilany Kogan. Sichot. (In Hebrew).

26. Szajnberg, N.M. (2014). Bettelheim: Living and Dying, by David James Fisher (Volume 8 of Contemporary Psychoanalytic Studies, Amsterdam and New York: Rodopi Press, 2008; 180 pp): reviewed by Nathan M. Szajnberg. *Psychoanal. Hist.*, 16:124-127.

27. Goldenberg, A. and Szajnberg, N. 2013 A Soldier's Loneliness. IN: Encounters with Loneliness. Eds. A. Richards, L. Spira , A Lynch. IPBooks. p 275-287.

28. Szajnberg, N. (2018). Lives Felt—Or Not: Reminiscences of a Viennese Psychoanalyst. By Richard F. Sterba. Detroit: Wayne State University Press, 1982, 184 pp., \$39.95 hardcover.. *J. Amer. Psychoanal. Assn.*, 66(3):595-599.

29. Szajnberg, N. (2018). Psychoanalysis: Perspectives on Thought Collectives. More Selected Papers by Arnold Richards, Volume 2, edited by Arthur Lynch, IPBooks, 2017, 382 pp.. *Psychodyn. Psych.*, 46(4):608-613

30. Szajnberg, N.M. (2018). Paul Ricoeur: Unraveling Enigmas in Psychoanalysis. *J. Amer. Psychoanal. Assn.*, 66(5):971-983.

Abstracts (selections)

1. Szajnberg, N. (1983). Visual Maturation and Part Object Mental Representations in the First One-Half Year of Life. In J. Call, E. Galenson, R. Tyson *Frontiers of Infant Psychiatry*.

2. Szajnberg, N., Ward, M.J., Krauss, A., Kessler, D. (1985). Severely Ill Premature Infants' Mothers' Attitudes. In *Behavioral Science*, Vol. 19:121A.

3. Ginsburg, B., Szajnberg, N., Buck. R. (1989). The Primacy of Affect in Modulating Phenotypic Expression in Social Systems. Paper presented at the 19th Annual Meeting of the Behavior Genetics Association. In *Behavior Genetics*, 19:758.

4. Ginsburg, B., Szajnberg, N., Buck, R., Dancer, S. (1993). Is Temperament Embedded in Attunement? Presented at Conference on Scalogram Analysis, Prague, Czech Republic, 1993.

Letters to the Editor (Selections)

1. Szajnberg, N. (1983). Critique: Anorexia Following Use of Extension Brace. *Psychosomatics*, 4:6, 493-494.

2. Szajnberg, N., Zalnairitis, E., Zemel, L. (1987). Unilateral Raynaud's Symptoms Evoked During Dream Report. *Lancet*: 8562, Oct. 3, p. 802.

3. Szajnberg, N. (1994). Medical Student Attitudes Toward Child Psychiatry. *J. of the American Academy of Child and Adolescent Psychiatry*: 33:1, p. 145.

EXHIBIT 2

Nathan Moses Szajnberg, M.D.

3941 Duncan Pl.

Palo Alto, Ca. 94306

nmoshe@gmail.com

650 272 8555

PRELIMINARY PSYCHIATRIC Assessment of Chloe Brockman

By Nathan Szajnberg, MD

REGARDING: Chloe Brockman DOB 7/27/04.

DATE OF REPORT: 1/29/24

Nathan Szajnberg MD: Boards in Child and Adolescent, Boards in General (Adult)
Psychiatry, Certified in Psychoanalysis

Qualifications to Conduct Evaluation:

I am both a board-certified psychiatrist and a board-certified child and adolescent psychiatrist. I am the Retired Freud Professor of Psychoanalysis at the Hebrew University. I am a certified psychoanalyst and training analyst.

Please see CV for further details.

Procedures:

Record Review including review of a detailed summary of background by Tim Crosby, Licensed Marriage and Family Therapist, review of paper/pencil testing performed, Kaiser mental health records, and educational records.

Series of **Interviews** of CB:

Interview 12/11/23 (four hours); 1/14/24 (four hours)

Relevant Background

History of Present “Illness”¹:

In brief, born with a cleft palate, Chloe was also jaundiced and needed breathing assistance at birth. Her milestones were normal, except for some eating difficulty and delayed full speech secondary to cleft palate. Cleft palate repair at 10 months. As detailed below, temperamentally, she was a slow-to-comfort child.

An IEP at school addressed motor delays. By three, she was shy and had tantrums. She had few friends from kindergarten through third grade and found solace in drawing, often forgetting to use the restroom or drink while drawing.

In second and third grade, at times, Chloe’s desk was moved outside the classroom or she was sent to the Speech room to calm down.

¹As this evaluation will document, Ms. Brockman’s major “Illnesses” today—both physical and psychiatric are iatrogenic, are directly due to inadequate diagnostic assessment and medically inappropriate interventions at Kaiser and its associated medical staff. I use the word “interventions” rather than “treatment,” since, as the reader will learn, there were no diagnostically-appropriate medical treatments due to questionable psychiatric diagnosis and intrusive interventions for a minor.

At nine, as described below, the family moved and Chloe, in retrospect became depressed. She received occupational therapy to improve her motor skills.

Around this time, she became involved in Minecraft which she continued until 17.

She was diagnosed with ADHD and the pediatrician recommended Concerta 18 mg. on 9/7/2015. She does not recall this as helpful but does recall having an almost tunnel vision focus, again forgetting to use the restroom or eat after a dose.

At 12, she told her parents she was transgender, after spending much time on the internet reading and interacting with others.

The following are **key dates** preceding and surrounding her “transition” interventions, which we will expand on further:

6/21/17: Assessment by “psychological assistant” for CB of depression. Despite the child’s chief complaint of depression, the assistant diagnoses her as “euthymic.”

10/3/17 Cleft palate revision

11/7/17; Hormone administration for transition initiated

(The “consent” states among other things that this 13 year old understood that she would have vaginal dryness and impaired reproductive functioning)

6/4/2020 Bilateral Mastectomy.

Ca. 12/20: First suicidality, depression with 25–30-pound weight loss².

Here is a more detailed review of the Kaiser interventions and the child’s reactions. As we review the record, note the number of changes in mental health providers with varying professional degrees, suggesting a lack of continuity of care. For instance, while an evaluation on 6/21/17 by one provider (Mr. Essestrom, LMFT) stated that Chloe did not have body image issues, a second assessment on 8/11/17 by Lilit

² As stated by Chloe.

Asulyan (“psychological assistant”) stated that Chloe had gender *and* body dysphoria. By 11/7/17, note that Ms. Asulyan now describes Chloe’s feeling “borderline disgusted” with her chest, hips and thin arms. The latter suggests at least considering the differential diagnosis of body dysmorphic disorder (which was not listed, although perhaps Ms. Asulyan was referring to this with “body dysphoria, without using the correct diagnosis). If Ms. Brockman had body dysmorphic disorder, surgery is contraindicated. It was after this visit, that Ms. Asulyan (countersigned by Ester Baldwin, LCSW, PhD.³) that Chloe “understood” and hence could give “informed consent” that exogenous hormone administration could cause adverse effects including vaginal dryness, egg production problems and sexual relationships. The latter was asked of a thirteen-year-old girl who had never had sexual relationships. Furthermore, Chloe’s IEP (at school) in 2013 documented that she had “...scored at least 1.5 standard deviations below the mean or below the 7th percentile in ...Pragmatics (social/functional) use of language.” *She had a disability in understanding the pragmatics of speech.* Hence, we question that she would understand questions about “egg production” or “sexual relationships” given that disability. Furthermore, neurodevelopmentally, as we discuss below, a thirteen or even fifteen-year-old *does not have sufficient neuropsychiatric brain development* (particularly of frontal lobe, a site for reasoning) to give informed consent for such consequential, even life-enduring adverse effects. The scientific literature supports what most readers of this report know from experience: the young through late adolescent tends to think and act impulsively; full reasoning ability is not developed until the early third decade (when myelinization of the frontal lobe is achieved.) Despite this,

³ What field this “Ph.D” was earned is not clear in the record. This could be relevant if it is not in psychology, for instance.

the clinician diagnosed the DSM 5 Gender dysphoria at that time, and expected this 13-year-old to understand *informed* consent. *Both her disability and her normative neurodevelopment incomplete maturation at that age would prevent her from understanding and consenting to both hormone and surgical interventions.*

By 7/8/19 after some two years of Lupron and testosterone, Chloe was seen by Susanne Watson PhD, who diagnosed her with Gender Incongruence, Unspecified (F64.9) and referred her for bilateral mastectomy at age 15. In the ensuing years, particularly after the mastectomy at fifteen, Chloe experienced a profound drop in grades academically, and the depression as mentioned earlier, and suicidality, which we will now detail from the interviews below, after we review the Kaiser psychiatrists' evaluations and diagnoses.

Formal Review of Psychiatrists' Diagnoses:

We suggest a specific review of Kaiser's psychiatrists' assessments, diagnoses and medication recommendations.

Chloe was seen 21 times by five psychiatrists: (a) Dr. Alisha Dunn; (b) Dr. Adam Pollack; (c) Dr. Teresita Mabaquiao Amay; (d) Dr. Anjileen Kaur Singh; and (e) Dr. Gurjot Singh.

Before "coming out", Chloe was primarily diagnosed with "disruptive behavior disorder" by the psychiatrists. There was a gap of over six-and-a-half-years between the earlier psychiatric visits (2010 – 2013) and the later psychiatric visits (2019 – 2021). The Kaiser psychiatrists did not diagnose Chloe as having "gender dysphoria" until December 2019, well after her hormonal interventions were begun, apparently based on the diagnosis of "gender dysphoria" made by prior mental health clinicians. In

December, 2019, Chloe was referred to a psychiatrist due to depression. Chloe saw this psychiatrist 10 times. Of those 10 appointments, seven of them list “depression” or “major depressive disorder” as the primary encounter diagnosis. The remaining three appointments list “gender dysphoria” as the primary encounter diagnosis. Of those three, the last two note that Chloe had stopped the testosterone and regretted the “gender-affirming care” in general. The remaining visit diagnosed with “gender dysphoria” occurred during her second appointment with this psychiatrist. This was early 2020—four months before the mastectomy.

- **Chloe was seen by a Kaiser psychiatrist 21 times:**

1. **4/1/2010** – Visit with Dr. Alisha Dunn (see KFH.Cole.003712 - KFH.Cole.003716);
2. **10/11/2010** – Visit with Dr. Adam Pollack (see KFH.Cole.003754 - KFH.Cole.003756);
3. **10/19/2010** - Visit with Dr. Adam Pollack (see KFH.Cole.003767 - KFH.Cole.003770);
4. **7/22/2011** - Visit with Dr. Adam Pollack (see KFH.Cole.003836 - KFH.Cole.003839);
5. **6/04/2012** - Visit with Dr. Adam Pollack (see KFH.Cole.003928 - KFH.Cole.003930);
6. **9/26/2012** - Visit with Dr. Adam Pollack (see KFH.Cole.004020 - KFH.Cole.004024);

7. **10/4/2012** – Visit with Dr. Teresita Mabaquiao Amay (see KFH.Cole.004026 - KFH.Cole.004033);
8. **12/17/2012** – Visit with Dr. Anjileen Kaur Singh (see KFH.Cole.004076 - KFH.Cole.004090);
9. **1/7/2013** - Visit with Dr. Anjileen Kaur Singh (see KFH.Cole.004112 - KFH.Cole.004114);
10. **2/11/2013** - Visit with Dr. Anjileen Kaur Singh (see KFH.Cole.004124 - KFH.Cole.004127);
11. **3/11/2013** - Visit with Dr. Anjileen Kaur Singh (see KFH.Cole.004139 - KFH.Cole.004141);

[Over six and a half years before seeing the next psychiatrist.]

11/7/17; Hormone administration for transition initiated: started Lupron and testosterone prior to double mastectomy.

Note: No psychiatric assessment for preparation for hormone interventions and **no psychiatrist assessments performed until 25 months after hormone interventions.**

12. **12/24/2019** – Visit with Dr. Gurjot Singh (see KFH.Cole.005015 - KFH.Cole.005020);
13. **2/12/2020** - Visit with Dr. Gurjot Singh (see KFH.Cole.005067 - KFH.Cole.005072);

14. **5/4/2020** – Video visit with Dr. Gurjot Singh (see KFH.Cole.005146 - KFH.Cole.005151);

6/3/2020 Bilateral Mastectomy.

15. **10/2/2020** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005406 - KFH.Cole.005411);

16. **11/20/2020** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005473 - KFH.Cole.005477);

17. **1/29/2021** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005515 - KFH.Cole.005520);

18. **2/26/2021** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005545 - KFH.Cole.005550);

19. **4/23/2021** – Video visit with Dr. Gurjot Singh (see KFH.Cole.005583 - KFH.Cole.005588);

20. **5/17/2021** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005637 - KFH.Cole.005641); and

21. **6/22/2021** - Video visit with Dr. Gurjot Singh (see KFH.Cole.005878 - KFH.Cole.005882).

- **History of diagnoses by psychiatrists**

1. **4/1/2010** – Dr. Dunn diagnosed her with “developmental delay”, code 315.9a (see KFH.Cole.003716).

- i. Notes from this visit state that Chloe has “behavioral issues social immaturity who presents for ASD screening”. (*Id.*)
2. **10/11/2010** – Behavior disorder, disruptive (primary) [312.9]; GAF 61-70, mild symptoms. [V79.9]
3. **10/19/2010** - Behavior disorder, disruptive (primary) [312.9]; GAF 61-70, mild symptoms. [V79.9]
4. **7/22/2011** – Behavior disorder, disruptive (primary) [312.9]; GAF 61-70, mild symptoms. [V79.9] (see KFH.Cole.003547)
5. **6/04/2012** – Dr. Pollack gave no diagnosis, but stated that “there is not sufficient evidence to diagnose Chloe with Attention Deficit Hyperactivity Disorder (ADHD).” (see KFH.Cole.003929).
6. **9/26/2012** - Disruptive behavior disorder (Primary Dx); GAF 51-60, Moderate Symptoms, Screening; Peer Problems (see KFH.Cole.003549)
7. **10/4/2012** - Disruptive behavior disorder (primary) [312.9]
8. **12/17/2012** – Diagnosis deferred (see KFH.Cole.004080);
9. **1/7/2013** - Diagnosis deferred (see KFH.Cole.004114);
10. **2/11/2013** - Disruptive Behavior Disorder (see KFH.Cole.004126);
11. **3/11/2013** - Disruptive Behavior Disorder (see KFH.Cole.004140);

[Over six and a half years before seeing the next psychiatrist.]

[Chloe has started Lupron and testosterone by now; not had the double mastectomy.]

12. **12/24/2019** – Depression (primary encounter diagnosis); gender dysphoria and ADHD (see KFH.Cole.005019);
13. **2/12/2020** - Gender dysphoria (primary encounter diagnosis); depression, unspecified (see KFH.Cole.005070);
14. **5/4/2020** – Major depressive disorder, recurrent episode, moderate (primary encounter diagnosis); Gender dysphoria in adolescents and adults; ADHD, predominantly inattentive presentation (see KFH.Cole.005149);

[Chloe has the mastectomy during this time period.]

15. **10/2/2020** - Major depressive disorder, recurrent episode, in partial remission (primary encounter diagnosis); ADHD, predominantly inattentive presentation; Gender dysphoria in adolescents and adults (see KFH.Cole.005409);
16. **11/20/2020** - Major depressive disorder, recurrent episode, in partial remission (primary encounter diagnosis); ADHD, predominantly inattentive presentation; Gender dysphoria in adolescents and adults (see KFH.Cole.005476);
17. **1/29/2021** - Major depressive disorder, recurrent episode, in partial remission (primary encounter diagnosis); ADHD, predominantly inattentive presentation; Gender dysphoria in adolescents and adults (see KFH.Cole.005518);

18. **2/26/2021** - Major depressive disorder, recurrent episode, in partial remission (primary encounter diagnosis); ADHD, predominantly inattentive presentation; Gender dysphoria in adolescents and adults (see KFH.Cole.005548 - KFH.Cole.005549);
19. **4/23/2021** - Major depressive disorder, recurrent episode, in partial remission (primary encounter diagnosis); ADHD, predominantly inattentive presentation; Gender dysphoria in adolescents and adults (see KFH.Cole.005586 - KFH.Cole.005587);
20. **5/17/2021** - Gender dysphoria in adolescents and adults (primary encounter diagnosis); ADHD, predominantly inattentive presentation (see KFH.Cole.005640); and
 - i. Notes in the chart indicate that by this time, Chloe has stopped taking testosterone and regrets taking it (see KFH.Cole.005638)
21. **6/22/2021** - Gender dysphoria in adolescents and adults (primary encounter diagnosis); ADHD, predominantly inattentive presentation (see KFH.Cole.005881).

- **How many times did all the psychiatrists give a primary psychiatric diagnosis of gender dysphoria? (Once, if at all.)**

No psychiatrist diagnosed or even considered the differential diagnosis of Chloe with body dysmorphia.

Let's review the above in terms of number of diagnoses, number of psychiatrists, and most significantly, in the timetable of Kaiser's hormonal/surgical approach to the (questionable) gender dysphoria diagnosis.

Prior to any hormone treatment: Chloe saw four Kaiser psychiatrists over eleven visits from 4/1/2010 through 3/11/2013 (from ages ~5 3/4 through ~8 1/2). Not one diagnosed gender dysphoria. Her diagnoses varied from developmental delay (with negative ASD screening) to behavior disorder to NOT ADHD (6/4/12; Dr Pollak) to multiple diagnoses of behavior disorder.

After starting Lupron/testosterone: there are three psychiatric visits on 12/24/19-5/4/20 (one month before mastectomy) with the new primary diagnosis of Depression and on 5/4/2020, Major Depression. For the first time, the psychiatrist also diagnoses Gender Dysphoria (without giving criteria) and now diagnoses ADHD.

After mastectomy: within four months, Chloe has the first of seven psychiatric assessments. The last two of which, Chloe expresses that she has ceased taking testosterone, regrets taking testosterone and wanted to reverse the effects of testosterone and the mastectomy. Despite this, the psychiatrist diagnoses her with Gender Dysphoria (and Major Depression, and ADHD). The Major Depression diagnosis is dropped 6/22/2021, two months after being given this diagnosis. No explanation is offered. This is puzzling, to have such a rapid remission for Major Depression without explanation.

First, note that this girl had psychiatric vulnerability prior to Kaiser's "Gender Dysphoria" initial diagnosis (made by Asulyan Psy.d.). One of the criteria for *not* initiating gender dysphoria diagnosis or treatment is whether the child has other

psychiatric morbidities. Per Kaiser's eleven visits over several different psychiatrists (prior to the interventions), she did have psychiatric morbidity and hence vulnerability.

Second, per Kaiser's psychiatrist, she never had a gender dysphoria diagnosis made by a psychiatrist until *after* her Lupron/testosterone administration. When the Kaiser psychiatrists do diagnose "gender dysphoria," they do not offer DSM criteria to meet the diagnosis.

Third, per Kaiser's psychiatrists, Chloe developed the more serious Depression and Major Depression diagnoses *after* her Lupron/testosterone administration. Perhaps more ominously, she was diagnosed with Major Depression, recurrent *one month prior to the bilateral mastectomy*. That diagnosis alone should have given Kaiser pause before the radical amputation of a fifteen-year-old's healthy breast tissue.

In summary, Kaiser's multiple psychiatric assessments do not indicate gender dysphoria prior to hormonal treatment, and diagnose gender dysphoria by a psychiatrist only after treatment was initiated.⁴ Further, Chloe's psychiatric state (Major Depression) worsened after the hormone treatments and surgery.

After this summary of the (Kaiser) psychiatric history, we turn to her interviews with this expert.

Psychiatric interviews (December, 2023 and January, 2024: eight-nine hours total)

⁴ Various Kaiser mental health clinicians used the gender dysphoria diagnosis, particularly Asulyan Psy.D. But for forensic purposes, we need depend on a nationally-certified MD Child/Adolescent psychiatrists for more definitive diagnoses, just as we would depend on a nationally certified MD pediatric endocrinologists or MD pediatric surgeons for medical/surgical diagnoses, even if they have reputable RNs, for instance, working with the MDs

Ms. Brockman is a handsome young woman with long dark hair, wearing red lipstick. She is articulate and makes an effort to make and maintain eye contact. On both occasions, she carried colorful and voluminous purses which she placed between her and the psychiatrist. She lives at home with her parents and has two older brothers and two sisters. She is not as close to her parents as she used to be. Her father is a "tech I.T. guy"; mother is an RN formerly working at Kaiser but, after Chloe's adverse experiences, now works at Sutter. Her mother is now 54, and father is 52. For a more detailed background history, see Mr. Tim Crosby's evaluation dated 8/14/23.

On **Mental Status Exam**, she is oriented to time place and person. She recalls what she had for breakfast, knows the three most recent presidents. She could recall two of three objects after several minutes. She recalled her breakfast on the first visit, and that she hadn't eaten on the second. (We took an early lunch break because she was hungry.)

When asked to give a family history, she recounted the history of medical interventions with *a sense of shame and judgment* for what she feels she's put her family through.

She has not yet talked heart-to-heart with her parents about the transitioning/detransitioning. She does not blame them for signing for the procedures, as they were threatened/warned that if they didn't approve the medical/surgical transitioning, Chloe would become suicidal and die. This is despite her never feeling *suicidal until after the Kaiser procedures*.

She feels that she had always struggled with socialization especially after her brother moved out of the house and she began pubertal body transformation. She recalls being needy as a child, yet difficult to communicate with, and very stubborn. She was diagnosed as ADHD, but questions that diagnosis today. She was placed on various medications, which she describes as “screwing with my neurochemistry.” With the medications, she felt headaches or something concrete in her brain. She sometimes became so hyper-focused that she forgot to eat or use the toilet. She felt she would snap out of a trance as the medication wore off.

Feeling alone, she turned to the internet for socialization and belonging. This is where she discovered the trans community. Before this, she describes herself as “burning bridges” with her peers at school, barging into friend groups, invading boundaries.

Chloe says that her mother describes Chloe’s birth as rough: she was born blue and not breathing. Her mother believes this was because mother was given too much pain medication. Chloe knows she was born with a cleft palate and had surgery at two years of age and again at thirteen because her artificial palate was not fitting properly with her growth. She shows no outward evidence of former cleft palate.

She learned to read via an “Animal Crossing” game at 4-5 years of age. She is told that she could not console herself and rejected physical affection. Yet, she recalls, she felt the need for physical affection. (See her later comment about touch deprivation.) When she was thirteen, she had a nasal voice because she expressed air

through her nose as she spoke, likely due to her cleft palate and its repairs. She recalls that her repaired palate felt itchy or sore when stressed.

At ten years of age (5th grade) they moved homes and she changed schools. She was bullied in grades first through third, yet had good friends in fourth grade, often around animé and video games. She felt “ripped away” from them with the move.

Her puberty began at 8 or nine years of age with breast buds. She got more attention from both parents and felt embarrassed. She recalled both wanting “boobs” and feeling sexy, yet afraid of them. Her menses began around twelve in seventh grade. She was first excited, then distressed and scared by their irregularity, scared that she was infertile or sick. At the same time, she recalls her sibling Chelsea having a rough time in high school.

She became focused on her body image: 1. Her tummy was too big; 2. Her hips too narrow; 3. Her face too boyish; 4. Her nose too big; 5 her boobs too big. She continues, “I felt worthless as a woman.” She repeated this phrase.

From the “Trans” internet, she developed the idea that she was a boy. She started social media at twelve with her first phone. Her parents ignored her use. Initially, she browsed animé and videos, then moved into LGBT/trans/pansex and gender material. She was especially absorbed by women who became transexual. She had crushes on both boys and girls on the internet. Given her artistic drawing, she was taken with the illustrations associated with the postings. She read and watched

“triumphant stories,” such as “Felt so Lonely,” “I wanted to be recognized” or “I didn’t want to be a wallflower.”

At this time, her paternal grandfather’s health plummeted when she was thirteen. It was rough for her and she recalls that he died due to an adventitious hospital infection, “neglect” in her mind.

In 9th or 10th grade, a student she didn’t know grabbed her butt, which distressed her, but she did not report, fearful that he would retaliate. She alludes to other sexual assaults. At school in a classroom, a boy squeezed her breast and “nobody noticed.”

Around then she felt she was a tomboy, although she didn’t engage in boys’ sports. With girls, she felt fearful about their “jokes.” With boys, they would *not* banter about frivolous things like dating or make-up.

She wrote a letter to her dad about coming out. He was supportive of her dress and pronoun but struggled with the medicalization of her body. Her parents chose Kaiser for assessment, as they had heard it was a top choice for gender issues. Her parents, however, thought that counseling was the correct course, not medical intervention until her adulthood. Her siblings showed different reactions. One brother was in the Navy; on a phone call, when he heard her post-testosterone deeper voice, her brother hated it.

Lupron was initiated and she experienced menopausal symptoms including hot flashes, itching, tingling, burning and lethargy. She chose the name, “Leo,” as it was both a lion in astrology and included three letters of her original name.

She was receiving monthly therapy appointments, but found that person “incompetent.” The second therapist pushed for a “gender dysphoria” diagnosis, also pushing the parents with threats of a 50% suicide rate if they did not sign for medical intervention. But, the first endocrinologist refused to treat arguing: 1. the “adverse effects on her brain⁵”; and 2. She had not gone through sufficient social transition.

A second endocrinologist approved Chloe for puberty blockers and testosterone in December 2017. Chloe began injections of puberty blockers and testosterone in January 2018 and February 2018, respectively. Chloe experienced paradoxically both a burst of sexual desire and the menopausal symptoms above, and a sense of confidence, yet a plummeting of her grades over the next few years. The latter—*a drop in cognitive functioning with puberty blockers/hormonal intervention—is now documented in both animal and human studies* (Barxendale, 2024).

Despite her online presence, she experienced increased loneliness. She also experienced sexual harassment both on the internet and with girls who would follow her around and stalk her. Men on the internet tried to groom her to meet at hotels, which she refused. It became harder to process her emotions with deeper and more frequent lows. She would literally bite her tongue to combat tearfulness. The tears were associated with her sense of loss, and the complications from the surgery, as well as

⁵ As stated by Chloe.

the sense of betrayal by the physicians and affiliated workers at Kaiser. When other kids spoke about college, Chloe would dissociate. This period during her “transition” was her “darkest point.” The last six to twelve months of the transition was “the worst time of my life...I felt I lost everything”.

The physicians were dismissive of her complications, both the hormonal adverse changes and the surgical complications. Her belief in the healthcare system “crumbled.” She developed urinary bleeding, **lost weight**⁶ felt **depressed and became suicidal**.

She now sees that the breast amputation when she was fifteen was “the nail in the coffin.” With complications from the skin graft including leaking fluid, open wounds, she told the surgeon she regretted the breast removal. He recommended applying Vaseline, which has not helped. The areola grafts were additionally troublesome. Even today almost four years after the surgery, she needs to redress the wounds.

Drug/alcohol use: prior to sophomore year, she started using marijuana and found it usually made her feel more energetic. She drank alcohol monthly. Her grades plummeted and withdrawal increased. While the marijuana made her feel more imaginative, her artwork became increasingly bizarre, and she retreated more into video games. She finally stopped marijuana, because it made her more irritable, with a significant increase in social anxiety and depression. She developed suicidal ideation

⁶ As stated by Chloe.

after the surgery and didn't think she would survive until eighteen years old. She hated herself and dissociated herself from her body and people and schoolwork.

In 10th grade, a friend reported Chloe's self-deprecation to her guidance counselor. Parents brought her to a different therapist, as she had no mental health treatment after eighth grade. She was diagnosed with major depression triggered by social anxiety and ADHD and prescribed bupropion and a stimulant.

The latter had adverse effects: she woke with bleeding lips, stinging secondary to dehydration and felt dissociated from her body. She was wearing a breast binder then.

She recalls the surgery preparation well. She was referred to surgery after less than six or seven months with the gender specialist. She recalls three appointments prior to surgery:

At the only classroom lesson on surgery: she freaked out as the other kids looked young and weird. On the day of surgery, she felt she was on the "final step in her transition." She remembers seeing a male nurse in the OR who looked uncomfortable, staring at her. She awoke a few times feeling the need to micturate. She thought to herself, "I can be that man I've always wanted to be."

The first following months focused on mobility rehabilitation. For three months she couldn't reach her arms over head, and couldn't turn her head around.

Because of Covid, she resumed online socializing. She felt isolated and had suicidal thoughts. Three months after surgery, she regretted her decision. She felt

overwhelmed by the overt sexual photos on the internet of girls. She missed looking feminine. In her room, privately, she resumed wearing makeup and dressing “girly.” She even wore makeup beneath her Covid masks. In her junior year, she feared developing male pattern baldness because of the exogenous testosterone. She began thinking about having a family with her own children.

In her psychology class, she read about the Harlow experiments with monkeys and breastfeeding. She felt she had lost “parts of myself as a woman before I could call myself an adult.” (At this point she was quietly crying, then composed herself.)

Academically, she **failed junior year**.

At this point, “detransitioning popped into my head.” On Subreddit, she read many, many pieces on detransitioning. *She felt she had been lied to by the Kaiser Transition doctors and affiliates.*

She grew out her hair, wore feminine clothes, bras and told herself, “Now, I’m just a woman.” She experienced guilt for what she had put her family through. As for her name, Chloe, “My name is a gift from my mom and dad after I was born.”

Interview 1/14/24 (12 pm-400 pm)

Ms. Brockman has been traveling a good deal associated with her work as an advocate/presenter for meetings opposing transexual interventions for children and teens. She’s also involved in at least one documentary that tries to present a more hopeful side to detransitioning and is directed by one of the Fast and Furious actors.

She became a Christian last year and this is also important to her. It emphasizes the more hopeful stance toward the future. Yet, as we progressed in the interview, it became more evident that the upbeat front that she's worked to develop the past few years is a veneer of "hypomania" to cover her despair over her current bodily damage. These include 1. chest mutilation and its ongoing painful sensations including phantom breast sensation phenomena such as when she runs or climbs stairs; 2. Vaginal pain on intercourse and bleeding as well as hematuria; 3. Forgoing sexual intimacy for the past months because of the symptoms mentioned.

That is, her upbeat front and her ability to look people in the eye and tolerate their looking into her eyes are achievements due to practicing for the past two years. She does not, when asked, feel these as fundamental states of mind.

Returning to her path to Christianity, she mentions that her father is/was Mormon and mother, Catholic. She attended Church with them until five years old. Then, beginning with her breast development, "she struggled with how to find myself." The online Trans community offered some camaraderie, although she felt alienated by how much they would bicker within that community.

A major component to her recent return to religion and God is her sense that humanity is so flawed, that there must be *something* else behind us. We can understand psychiatrically that after the multiple and serial betrayals by the Kaiser medical community, she would believe that humanity is flawed, particularly those (physicians and affiliates) whom we expect would care for us.

She recalls crisply her surgery on June 4, 2020. That following summer, her junior year, she “went pretty crazy.” She got LSD from friends and did three “trips.” During one, she stayed curled up in a fetal position, crying, naked with tears and snot and began to regret her transitioning. She then felt a presence behind her, a sense it was a part of herself, saying “you’re not being honest with yourself.” “You’re living a lie.” “You need to start growing up.” It was a woman’s voice, hers. She began to think “The Holy Spirit was speaking through me.” She hopes to be baptized this year.

She recalls that as a child, while she felt socially awkward, she could present in a bubbly manner, until she underwent the trans experience. Now she feels she is “not living a lie anymore, is back in full force.”

Chloe describes idiosyncratic childhood sensations. From early childhood, she felt uncomfortable dealing with people and often had meltdowns. She’s had difficulty regulating emotions and hated eye contact. She’s averse to touch or even saying “I love you.” Other sensory oddities include her smelling yogurt caused her to cry as a child. She is unable to tolerate itchy polyester and would only wear shoes that were made by Toms or Converse. She couldn’t tolerate long hair. Public bathrooms are anathema to her because of the echos, artificial lights, and automatic flushing.

During the trans period of endocrinological administration and surgery, she did not date, felt lonelier, felt she was a loser. She was glued to the internet including porn films that her internet friends were suggesting.

Prior to the trans experience, when she was eight or nine, she developed breasts and felt both excited and stressed. Boys paid attention, which was both positive and negative. One boy fondled her breasts in eighth grade, which she found upsetting, but was afraid to tell anyone as he might retaliate further. She felt, “My body was growing faster than I was.”

With the testosterone bolus injections, she felt a sudden surge of hypersexuality that was hard to handle. She points out that normal boys have more gradual increases in testosterone; she had a bolus of injected hormone. She had a sudden increase in “touch starvation.” She considered herself “straight,” yet with the physical transformations of her body and renaming herself “Leo,” she experienced more physical and sexual assaults from women than men. “It opened my eyes to the loneliness of young men. I felt very lonely.”

In retrospect, she interrupts herself and says poignantly, “When I was twelve, my day was its healthiest.” She feels that more so today. She mentions the vaginal atrophy and associated pain with intercourse. When she described this to Jordan Peterson, she broke into tears. She can’t predict when she will start crying over her current pain and suffering; at times it will happen when she is giving a presentation; this makes her feel uncomfortable, as she tries her best to put on an optimistic front.

More recently, when asked about endocrinological assessment and gynecological functioning, she gives more details. While on the trans endocrinological medications, she developed menopausal symptoms and became suicidal, the first time

in her life she'd thought about killing herself. Her periods were becoming more and more regular after stopping testosterone until she started and then stopped birth control. An endocrinologist did not suggest birth control — she started taking birth control at 17 years old, partly to address premenstrual-onset depression. She was prescribed birth control by an online service. Joint pains, another symptom that she developed on hormone blockers and testosterone, persist. She repeats that her breasts “look like crap” and are numb on the areola. She again describes the persistent “weeping” around her wounds and strange uncomfortable painful sensations around the wound margins. She also repeats her “phantom” sensation of feeling that her breasts are still there when she climbs stairs or with some movement. “I feel like I’ve been de-sexed.” She notes that on testosterone, her upper body is broader and her hips narrow. “I look in a mirror and see a fifteen-year-old boy. ...I don’t look like an adult woman.”

When asked about sexual intimacy, she can recall her first partner after the detransitioning, but try as she might, cannot recall the sexual experience. She does recall that later sexual experiences with this man were a feeling of numbness. “I feel guilty because I didn’t feel anything in sex...it killed me inside.” Her partner was puzzled as he had brought pleasure to other women. Most recently, Chloe has forgone sex because *intercourse is such an adverse physical (and consequentially emotional) experience.*

She describes her unusual sensory reactions since early childhood, for which Kaiser suggested and gave her two evaluations for “autism,” neither of which assessments resulted in definitive diagnoses. The first evaluation was when she was four or five years old. The second evaluation was recommended by her gender dysphoria specialist when Chloe was sixteen or seventeen. The latter evaluation was suspect to Chloe, as Chloe disagreed with the gender specialist’s original diagnosis of gender dysphoria; how could she trust this person’s referral for autism?

She’s aware that in the past two years, with practice, she has overcome her aversion to eye contact and her discomfort talking to others. This has taken effort and repeated practice.

We reviewed her academic high school path. Her grades plummeted after the transitioning endocrinological interventions. She became apathetic in Freshman year and had waves of depression during the transitioning. This is consistent with the recent research on *cognitive decline after hormonal administration including pubertal blockers* in animals and human case reports.

<https://www.authorea.com/users/713322/articles/697715-the-impact-of-suppressing-puberty-on-neuropsychological-function>).

She recalls depressive experiences in fourth grade after she moved homes and missed her peers. A second depressive episode occurred in sixth grade when her brother moved out.

But her cycles of depression worsened after endocrinological and surgical interventions by Kaiser. She has periods of being unable to function at her work (missing the making of needed Instagram posts), and sleep onset difficulties (sleep onset as late as 400 a.m.) with depressive moods.

Since surgery, she has had disturbing dreams of having her breasts back or being a child again or having normal sex life with orgasms with a partner. For her, fantasy about sex is better than the reality with vaginal pain or numbness around her breasts.

She does hope to have breast reconstruction, knowing that they will not be able to restore the sensory nor lactation functions. She understands now that when she was “informed” in her early teens that she would lose these functions, she did not understand what she was agreeing to. Nor, as we will discuss, given her neurobiological lack of maturity, could she understand these statements about future childbearing and body functioning at her level of neurobiological maturity in her early to mid-teens.

Research foundations

The most parsimonious scientific explanation for Chloe Brockman’s state of mind (and physical suffering since breast amputation) is that the child’s previous condition was undermined by inadequate/inaccurate medical diagnoses followed by inappropriate, medically and surgically unnecessary procedures (misnamed and misleading to the teenage Chloe, as “treatment”) performed by Kaiser and its

employees. Kaiser was/is responsible for hiring and overseeing physicians and allied healthcare professionals to safeguard the children in its care.

Her traumata are complex and profound.

Her traumata consisted of negligently supervising physicians and health care providers, in not performing adequate complete *psychiatric* assessments (by an MD trained in child/adolescent psychiatry done in the early phase of her assessment) of this young teen and her family, and then proceeding with making a psychiatric diagnosis with endocrinological manipulations and breast amputations with no valid *medical/surgical* diagnosis (i.e. no endocrinological disorder; no breast pathology).

We remind the reader: the psychiatric diagnosis of Gender Dysphoria was NOT made by any psychiatrist at Kaiser until some two years into the administration of hormones. Non-MD clinicians made this diagnosis. MD specialists in endocrinology or surgery then used this psychiatric diagnosis for non-psychiatric, endocrinological or surgical interventions. Further, inadequate, even the incomplete psychiatric assessments suggest some criteria for Body Dysmorphic Disorder, for which surgery is contraindicated.

Kaiser Hospital's failures are experienced by this now young woman as betrayals, with loss of trust in medical professionals.

Psychiatric research has grown on both gender dysphoria and trauma in childhood and adolescence.

For Gender dysphoria, a recent review of three major studies concludes: “Evidence conducted by public health authorities in Finland, Sweden, and England concluded that the *risk/benefit ratio of youth gender transition ranges from unknown to unfavorable*. As a result, there has been a shift from “gender-affirmative care,” which prioritizes access to medical interventions, to a more conservative approach that addresses psychiatric comorbidities and psychotherapeutically explores the developmental etiology of the trans identity.” (Levine and Abbruzzese. 2023). Ironically, had Kaiser participated in such empirically valid research, it could have contributed to the field and would have stopped such procedures, saving Chloe Brockman and others from adverse consequences.

The irony here is that Chloe Brockman *did not have gender dysphoria*; even the four Kaiser psychiatrists (Dunn, Pollak, Mabaquiao Amay and Singh) who saw Chloe did not diagnose her with this at any time before her hormonal treatment was initiated, allegedly for “gender dysphoria.”

Neuroscience shows that three anatomical brain areas commonly have altered function in PTSD: *prefrontal cortex, amygdala, and hippocampus*.

With high stress, such as associated with profound endocrinological manipulations such as “blocking” and testosterone, followed by breast amputations, the hippocampus is suppressed (the hippocampus functions as the ability to place memories in the correct context of space and time, and to recall the memory). This suppression is hypothesized to be the cause of PTSD flashbacks: a stimulus similar to the traumatic event causes the person to perceive the event as recurring (Newport, et. al. 2012).

Neuropharmacologically and endocrinologically, the LC-noradrenergic system is hypothesized to mediate fear memory in PTSD. Elevated cortisol levels associated with trauma reduce noradrenergic activity: those with PTSD may not regulate the increased noradrenergic response to traumatic stress. This results in intrusive memories and conditioned fear responses to associated triggers. (Vermetten and Lanius, 2010).

Clinically, in a thirty-year prospective study of infants, those with childhood traumata, are at risk for later life adverse functioning, what is referred to as “sleeper effects” (Szajnberg, et. al., 2010). Szajnberg’s work (2010) also shows that youth with two or more traumata have precipitous drops in Global Assessment Functioning (GAF) by age thirty: in Chloe’s case, Kaiser’s endocrinological manipulation after an incomplete medical/psychiatric and family history is a first trauma; the Hospital’s failure to protect her from later mutilating surgery removing healthy breast tissue is a second trauma. Later traumata include Kaiser’s (this includes the physicians and allied personnel) lack of, or incorrect, assessments and her subsequent severe psychiatric

reactions and ongoing endocrinological treatment of a non-endocrinological, (normal endocrinological) body. This 30-year study is currently supplemented by a 60-year follow-up of select subjects (Massie and Szajnberg, in progress)⁷

Based on review of the chart mental health notes, one psychiatric diagnosis that should have been considered was body dysmorphic disorder (<https://www.womenshealth.gov/mental-health/mental-health-conditions/body-dysmorphic-disorder>. Accessed Aug. 18,,.2021)⁸

We do see evidence of this diagnosis on our first evaluation, and based on the chart history, for instance, in our first interview, Ms. Brockman was concerned about having plastic surgery on her face, chin line, and possibly other body areas (including repairing the mutilation to her breasts and chest). On our second interview, a month later, Ms. Brockman reconsidered all these surgical procedures and did not want to pursue them except for her breast and chest repair. On history, Ms. Brockman was preoccupied with her body shape, not only her breasts, but also her hips, and chin line, checking herself in her room or a mirror repeatedly, and trying to disguise her body appearance with clothes or a binding cloth. Body dysmorphic disorder would have been a more parsimonious diagnosis than gender dysphoria at the time of her assessments. Also, body dysmorphic disorder is a psychiatric diagnosis for which

⁷ Ironically, the ACES studies that document the later effects of youth trauma was developed primarily at Kaiser Hospital. If Kaiser had researched as careful studies of outcome on their gender dysphoria cases, they would have contributed to the growing literature of the adverse outcomes on adolescents.

⁸

surgery is contraindicated. Yet, Ms. Brockman was not seen by an MD psychiatrist until several years into her “interventions” (12/24/2019, less than six months before surgery), who diagnosed her with depression. On 5/4/2020 (one month before surgery), this same psychiatrist diagnoses Ms. Brockman with major depressive disorder for the first time. We can recognize that the severe degree of depression was subsequent to the “transitioning” hormone interventions. Similarly, Ms. Brockman began to feel suicidal nearly three months after the mastectomy, and then again approximately one year after the mastectomy.

Furthermore, this girl was born with cleft palate and had revisions at two points in her life, the last shortly before her “transitioning” interventions. There is sufficient literature to support that children with cleft palate will have other body image concerns (and ambivalence about surgery). Yet, nowhere in the chart is there evidence of a thoughtful consideration of the cleft palate, its recent revision, and the girl’s concerns about her body. This is remiss for a psychiatric assessment at age thirteen and later.

Diagnostic Impressions as of 1/14/2024

Axis I:

1. **PTSD** (309.81) (F43.10) secondary to (**Criterion A**) to traumatic endocrinological manipulations (with no recorded endocrinological abnormalities) and medically unnecessary breast amputations of healthy breast tissue. She has (**Criterion B**): recurrent intrusive memories; and (**Criterion C**): Avoidance of memories (When pressed, Chloe will describe the adverse reactions to hormonal manipulation and

surgical amputation, but is distressed and at times breaks into tears, lamenting the loss of her womanhood); and **(Criterion D)**: Negative mood and cognition, as evidenced by her reactions to discussing both mastectomy, surgeon's lack of concern about weeping wounds, Kaiser clinicians' unconcern about the negative aspects of her response to Lupron and testosterone, and their lack of concern about her depressive and suicidal reactions to Lupron/testosterone/mastectomies ;**(Criterion E)**: Exaggerated negative thoughts about oneself, others, or the world and blaming oneself or others for the trauma; Persistent negative emotional state, shame.

2. **Depression, NOS**, possibly with multiple lower swings. And hypomanic defense against depression.

3. **Body dysmorphic disorder** (by history) in remission.

4. **History of ADHD**, possibly in remission (See Barkley et. Al (2021) on remission of childhood ADHD in some 60% of adults with prior childhood ADHD).

Axis II: NA

Axis III:

1. History of administration of medically unnecessary testosterone and other endocrinological manipulations with no valid endocrinological diagnosis;

2. Sequelae of *medically unnecessary breast amputation* with subsequent numbness, wound weeping and future inability to breastfeed.

Axis IV:

1. Betrayal by Kaiser Hospital

2. Endocrinological and Surgical Maltreatment for *no valid medical nor surgical diagnosis*.

Axis V: Estimated Childrens Global Assessment Scale (CGAS)⁹ (GAF for children)

before Kaiser:

80

Current GAF:

39 (Major impairment in sexual intimacy and intimate relationships.)

NOTE THE *DROP OF SOME 41 points in GAF* due to Kaiser's inappropriate and medically negligent treatments.

Opinion

The nature of PTSD is that it can become a chronic, intermittent and recurring illness with triggers both in the environment (such as physical intimacy) and internally (such as her thoughts about the incidents). Ms. Brockman also has decreased trust in

⁹ Shaeffer et. Al. 1983:

- 1-10: Needs constant supervision (24 hour care)
- 11-20: Needs considerable supervision
- 21-30: Unable to function in almost all areas
- 31-40: Major impairment in functioning in several areas and unable to function in one of these areas
- 41-50: Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area
- 51-60: Variable functioning with sporadic difficulties or symptoms in several but not all social areas
- 61-70: Some difficulty in a single area, but generally functioning pretty well
- 71-80: No more than slight impairment in functioning
- 81-90: Good functioning in all areas
- 91-100: Superior functioning

medical agencies (Kaiser and its staff) that betrayed her, whom she expected should protect and care for her. She has developed with her own training some adaptive capacities: She has been training herself to look others in the eye when she speaks with them; she realizes that if she keeps herself active in opposing transitioning, she will wade off temporarily depressive feelings and specifically her ongoing despair about the damage done to her breasts/chest, her concerns about her menses and fertility, and her inability to have intimate sexual relations that are mutually gratifying. She has what we would call psychiatrically, a hypomanic defense against her depression. And her depression is directly related to Kaiser's hormonal and surgical interventions.

A further clarification about her active, driven engagement with opposing transitioning as an aspect of PTSD itself. We see this often in soldiers with PTSD after war. They will engage in counterphobic behavior, that mimics the experienced traumata. /This may range from preoccupation with active shooter video games (to an addictive extent) to engaging in dangerous activities such as rock-climbing or parachuting or racing. This is an attempt to "control" the trauma that was previously passively experienced: to now actively immerse oneself in traumatic events. Ultimately, this defense against the PTSD and associated depression may work for a while, but it fails, that is, she will fail. Treatment is necessary to return the patient to normative non-traumatic functioning.

She will need several years of treatment, both intensively now and in the future, as she approaches major life events such as dating, marriage and child-bearing and

child-rearing, *should she be able to achieve these, given Kaiser's (medically inappropriate) endocrinological and surgical interventions.*

She also shows that despite her inherent intelligence, she has cognitive impairment and obsessions about Kaiser's betrayal that interfere with optimal academic and vocational functioning. For the moment she has secondary gain, using her preoccupation with Kaiser's medical/surgical betrayal as an almost full-time job. Yet, after this is resolved, and after Kaiser attempts to compensate for the damage done to her, Ms. Brockman will need to find other ways to invest her time and energy. And she is at risk for depression should she not find other meaningful activities. Her "energetic" pursuit to protect other adolescents and families from her "trans" vicissitudes, is a form of hypomanic defense against the depression she reveals periodically as she breaks into tears over both her current adverse consequences of the breast amputation and future (and present) concern about her capacity for both intercourse and childbearing.

Treatment Recommendations

Rationale for recommendations:

A brief overview of Ms. Brockman's treatment for PTSD (and associated depression and anxiety) is as follows.

As she progresses through normative developmental life events, such as dating, marriage, and childrearing, she will need supportive psychotherapy to deal with crises that are triggered by the life events.

Note: it is the nature of PTSD that it can be triggered by normative events in life that otherwise would not disrupt someone not affected.

Intensive outpatient exploratory psychoanalytic psychotherapy to overcome PTSD secondary to medical/surgical treatment and to clarify and solidify identity, including sexual identity. Five times weekly for five years with trained and nationally certified psychoanalytic psychotherapist, also experienced in working with traumatized young adults:

Cost \$600/session @240 sessions/year = \$144,000/year X 5 years = \$720,000.

Maintenance continued supportive and exploratory psychotherapy twice weekly: Cost:

\$600/session twice weekly @ 100 sessions/year for five years: \$228,000

Marital counseling to overcome sexual dysfunction secondary to hormonal/surgical

interventions: two years, weekly counseling @ \$800/session = \$80,000

Counseling during fertility/pregnancy issues: 6 mos. weekly @\$600/session = \$15,480

Parent/infant counseling during caregiving and feeding twice weekly for first eight months of infant caregiving to facilitate attachment (following Ainsworth and colleagues' suggestions for secure attachment) with videotaping:

8 months twice weekly @\$800/session =

\$27,520

Referral to University of Chicago post-mastectomy reconstructive and resensitization program¹⁰ (Lindau, 2023) (Cost to be determined)

Health care costs overcontrol patient levels due to ACES score (based on Marciniak, Felliti, Dubet, Centers for Disease Control information): Please consult a medical economist for an estimate of increased **medical** care costs over the lifetime due to adverse psychological childhood experiences associated with Kaiser's interventions.

We assume an additional 55-year lifespan, but this may be revised by a medical economist.

Cost of lost income due to cognitive and academic impairments following Kaiser's hormonal and surgical interventions (suggest calculating with U. S. Labor Dept. regarding effects of school level achievement on lifetime earnings).

Additional loss of achievement beyond high school, given her response to assaults without treatment.

As it stands, this woman has not been able to complete a standard high school degree. But her intellectual potential, given her history and inherent cognitive potential,

¹⁰ This is an experimental program for women post-mastectomy to help not only anatomical reconstruction but also resensitization of the areola and breast.2023: <https://reporter.nih.gov/search/UBJlxHZWLESM-BdnMIRe1g/project-details/10753314>.

would be that she had the ability to at least to complete college and possibly professional school beyond that.

Because of her profound drop in academic functioning shortly after Kaiser's interventions, the literature supports a drop in lifetime earnings. We defer to an economist's opinion.

Pain and Suffering

A fact finder would need to consider:

General psychological: Thousands of moments of distress above pre-existing levels

Specific Sexual: Thousands of adult life reminders associated with betrayal, disgust and fear;

General Social: Loss of self-esteem in the social world. She has been trying to reconstruct some sense of self-value through her advocacy work against transgender approaches to youth. But this will end and she will face the need to build an alternative sense of self-worth;

General parenting: Inability to breast-feed, and impaired ability to protect and care for offspring, *should she be able to bear children*, given her endocrinological manipulation by Kaiser; and

General Diminished freedom to trust others.

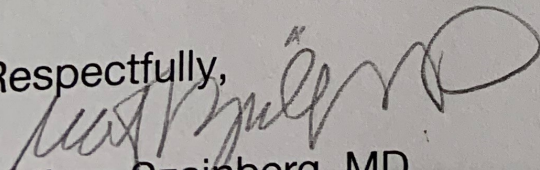
I give all the above opinions as medically probable and based on reasonable medical certainty. They are based upon scientific literature and my own decades of child adolescent and adult treatments, long-term follow-up, supervision of treatments

by other professionals, and my evaluation experiences with thousands of traumatized children and adults.

Prognosis

Guarded, but some improvement is expected with the timely, recommended treatments. Note, the recommendation for the University of Chicago breast resensitization program is a medical/surgical intervention, but with profound psychological implications.

Respectfully,


Nathan Szajnberg, MD

2/7/24

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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

SERVICE LIST

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