

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS**

JANIAH MONROE, MARILYN)
MELENDEZ, LYDIA HELÉNA VISION,)
SORA KUYKENDALL, and SASHA)
REED,)

Plaintiffs,)

v.)

Civil No. 3:18-cv-00156-NJR-MAB

JOHN BALDWIN, STEVE MEEKS, and)
MELVIN HINTON,)

Defendants.)

DECLARATION OF DR. RANDI ETTNER

I, Dr. Randi Ettner, hereby state:

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of Gender Dysphoria.

2. I have been retained by counsel for the named plaintiffs and putative class in this case to provide my expert evaluation and opinion regarding the appropriateness of the treatment for Gender Dysphoria provided by the Illinois Department of Corrections (“IDOC”). This declaration provides my opinions and conclusions, including (i) scientific information regarding Gender Dysphoria and its impact on the health and well-being of individuals living with the condition; (ii) information regarding best practices and the generally accepted standards of care for individuals with Gender Dysphoria; and (iii) the results of my review of both the named plaintiff and putative class members’ treatment for Gender Dysphoria. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

I. QUALIFICATIONS

3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

4. During the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance from 1977 to the present.

5. I have published four books related to the treatment of individuals with Gender Dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Rutledge 2007); and the 2nd edition (co-editors Monstrey & Coleman; Routledge, 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of The International Journal of Transgenderism and Transgender Health. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (“WPATH”), and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,000 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Incarcerated Persons, and provide training to medical professionals on healthcare for transgender inmates.

7. I have lectured throughout North America, Europe, and Asia on topics related to Gender Dysphoria and have given grand rounds on Gender Dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of Gender Dysphoria. I received a commendation from the U.S. Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and Gender Dysphoria in Illinois.

8. I have been retained as an expert regarding Gender Dysphoria and the treatment of Gender Dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with Gender Dysphoria in prison settings. I provided testimony and/or was deposed as an expert in the following cases over the past four years: *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW (D. Idaho 2018); *Faiella v. Am. Med. Response*, No. HHD CV-15-6061263 (Conn. Super. Ct. 2015); *Broussard v. First Tower Loan*, No. 2:15-CV-011-61 (D. La. 2016); *Carrillo v. U.S. Dep't of Justice Exec. Office of Immgr. Rev.* (2017); *Jane Doe v. Clenchy, et al.*, No. CV-09-201 (Me. Super. Ct. 2011); *Kothmann v. Rosario*, No. 13-CV-28-OC22 (D. Fla. 2013).

9. In addition, I have been a consultant to news media and have been interviewed as an expert on Gender Dysphoria for hundreds of television, radio and print articles throughout the country.

10. A true and correct copy of my *Curriculum Vitae*, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as Appendix A.

II. MATERIALS CONSIDERED

11. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive experience and review of the literature related to Gender Dysphoria over the past three decades. Attached as Appendix B is a bibliography of relevant medical and scientific materials related to transgender people and Gender Dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration.

12. The additional materials I have reviewed and relied on in this case are the following: the named Plaintiffs' medical records; the putative class members' medical records; Transgender Committee/GID Committee records; records of IDOC grievances; IDOC policies, procedures, and training materials related to transgender prisoners and prisoners with gender dysphoria; the responses of the Defendants in this litigation to the Plaintiffs' interrogatories; and the deposition transcript for Plaintiffs' deposition of IDOC's Rule 30(b)(6) designees. Finally, I conducted and relied on in-person interviews of the named plaintiffs in this case in May 2018. During those interviews, I conducted and subsequently reviewed and considered the following psychodiagnostic tests: the Beck Anxiety Inventory; the Beck Depression Inventory-II; the Beck Hopelessness Scale; and the Traumatic Symptom Inventory-II.

III. GENDER DYSPHORIA

13. The term “gender identity” is a well-established concept in medicine, referring to one’s internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female.

14. At birth, infants are typically classified as male or female. This classification becomes the person’s birth-assigned gender. Typically, persons born with the external physical characteristics of males psychologically identify as men, and those with external physical characteristics of females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one’s self—one’s gender identity—differs from the birth-assigned gender, giving rise to a sense of being “wrongly embodied.”

15. For some, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in Gender Dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one’s assigned gender.

16. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

17. In 2013, with the publication of DSM-5, the Gender Identity Disorder diagnosis was removed and replaced with Gender Dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that

gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's *identity* disordered. Rather, the diagnosis is based on the distress or *dysphoria* that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis connoted "that the patient is 'disordered.'" American Psychiatric Association, Gender Dysphoria (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf. But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition." *Id.* By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013).

18. In addition, the categorization of Gender Dysphoria and its placement in the DSM system is different for Gender Dysphoria than it was for GID. In every version of DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own. And as recently as June 16, 2018, the World Health Organization (WHO) likewise reclassified the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because the new classification removes gender incongruence from the chapter on mental and behavioral disorders, recognizing that it is not a mental illness.

19. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
 - 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).
 - 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

20. In addition to renaming and reclassifying Gender Dysphoria, the medical research that supports the Gender Dysphoria diagnosis has evolved. Unlike DSM's treatment of GID, the DSM-5 includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria").

21. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology. It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.,* Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment: A Diffusion Tensor Imaging Study*, 45 J. Psychiatric Res. 199–204 (2011); Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study*, 45 J. Psychiatric Res. 949–54 (2011); Luders et al., *Gender effects on cortical thickness and the influence of scaling*, 2 J. Behav. & Brain Sci. 357, 360 (2006); Kruijver et al., *Male-to-female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034–41 (2000). Interestingly, differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one’s own body, and the link between the physical body and the psychological self.

22. In addition, scientific investigation has found a co-occurrence of Gender Dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. Gomez-Gil et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265–69 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of Gender Dysphoria. *See* Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int’l J. Transgenderism 24 (2013) (abstract: “[t]he responses of our

twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing.”). *See also* Green, *Family co-occurrence of “gender dysphoria”: ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499–507 (2000).

23. It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

[d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one’s postnatal social environment plays a crucial role in gender identity or sexual orientation.

Garcia-Falgueras & Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 Pediatric Neuroendocrinology 22–25 (2010). Similarly,

Lauren Hare et al. finds that:

a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Hare et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to- Female Transsexualism*, 65 Biological Psychiatry 93, 93, 96 (2009). Because Gender Dysphoria is biologically based, efforts to change a person’s gender identity are futile, cause psychological harm, and are unethical.

IV. TREATMENT OF GENDER DYSPHORIA

A. WPATH Standards of Care

24. Gender Dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of Gender Dysphoria are set forth in the *World*

Professional Association for Transgender Health (WPATH) Standards of Care (7th version, 2011). The WPATH promulgated Standards of Care (hereafter, “SOC”) are the internationally recognized guidelines for the treatment of persons with Gender Dysphoria, and inform medical treatment throughout the world. The American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the SOC. *See, e.g.,* American Medical Association (2008) Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

25. As part of the SOC, many transgender individuals with Gender Dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for Gender Dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one’s gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized

transphobia; enhancing social and peer support improving body image; or promoting resilience.

SOC at 9–10.

26. The treatment of incarcerated persons with Gender Dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of Gender Dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the SOC for people in correctional settings. *See* NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), [http:](http://www.ncchc.org/transgender-transsexual-and-gender-nonconforming-health-care)

[//www.ncchc.org/transgender-transsexual-and-gender-nonconforming-health-care](http://www.ncchc.org/transgender-transsexual-and-gender-nonconforming-health-care)).

27. Under the SOC, while it is true that “[r]easonable accommodations to the institutional environment can be made in the delivery of care consistent with the [Standards of Care],” “[d]enial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations” SOC at 68.

28. Once a diagnosis of Gender Dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

29. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with Gender Dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. *See* Section VII. In particular, the SOC provide that all mental health professionals should

have certain minimum credentials before treating patients with Gender Dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from Gender Dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of Gender Dysphoria; and continuing education in the assessment and treatment of Gender Dysphoria. SOC at 22.

30. Importantly, the SOC require that “[m]ental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.” *See* SOC at 22–23. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of Gender Dysphoria, or the mentorship and supervision of an expert in this field.

31. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care.

32. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care, or place patients at significant risk.

33. While psychotherapy or counseling can help with the personal and social aspects of a gender transition, they are not a substitute for medical intervention where medical intervention is needed, nor are they preconditions for such intervention. By analogy, in Type One diabetes,

counseling might provide psychoeducation about living with a chronic condition, and information about nutrition, but it does not obviate the need for insulin.

34. For many individuals with Gender Dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called the "real life experience" or "social transition," are an important part of treatment for the condition. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

B. Hormone Therapy

35. For almost all individuals with persistent, well-documented Gender Dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. The Standards of Care specify that "feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender non-conforming individuals with gender dysphoria." SOC at Section VIII, p. 33.

36. Hormone therapy is a well-established and effective means of treating Gender Dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all agree that hormone therapy in accordance with the WPATH Standards of Care is medically necessary treatment for many individuals with Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice

Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

37. The goals of hormone therapy for individuals with Gender Dysphoria are (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.*, non-transgender males born with insufficient testosterone or non-transgender females born with insufficient estrogen). *See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

38. The therapeutic effects of hormone therapy are twofold: (i) with endocrine treatment, the patient acquires congruent sex characteristics, *i.e.* for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (ii) hormones act directly on the brain, via receptors sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of a sense of well-being. *See, e.g.*, Cohen-Kettenis & Gooren 1993. Hormone therapy induces desired physical changes for transgender men as well, such as deepened voice, growth in facial and body hair, cessation of menses, and atrophy of breast tissue, among other changes. SOC at 36.

39. The efficacy of hormone therapy to treat Gender Dysphoria is clinically evident and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormones and compared them with a group of transgender individuals who did not. Untreated individuals showed much higher levels of

depression, anxiety, and social distress than those who received hormone therapy. *See* Rametti, et al. 2011; *see also* Colizzi et al. 2014; Gorin-Lazard et al. 2011.

40. Some individuals with Gender Dysphoria experience profound relief from hormone therapy alone such that further treatment, such as surgical intervention, is not required. *See* SOC at 8–9.

41. While the WPATH Standards indicate that significant mental health concerns must be reasonably well-controlled prior to initiation of hormone therapy, co-occurring mental health conditions should only be a reason to delay therapy in the most exceptional circumstances. For example, a physician would not initiate hormone therapy in a patient who is so delusional as to be unable to consent to the treatment plan. Otherwise, it is extremely common for gender dysphoric patients to present with co-existing mental health issues and past trauma, which usually are a result of their underlying gender dysphoria. There is no legitimate medical basis for denying treatment simply because a patient also has been diagnosed with, for example, anxiety, depression, or PTSD.

C. Gender-Affirming Surgery

42. For some individuals with severe Gender Dysphoria, hormone therapy alone is insufficient. Relief from their dysphoria cannot be achieved without surgical intervention. Under the contemporary understanding of gender identity, transition-related medical treatments confirm, not “change,” an individual’s sex by aligning primary and secondary sex characteristics with a person’s gender identity. The WPATH Standards state: “While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.” SOC at 54–55.

43. Genital reconstruction surgery for male-to-female transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the uro-genital structures appearing and functioning as is typical for non-transgender women. Both are critical in alleviating or eliminating Gender Dysphoria. Other forms of gender-affirming surgeries, such as bilateral mastectomy for transgender men, allow the individual to attain body congruence with respect to secondary sex characteristics.

44. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgery is a safe and effective treatment for severe Gender Dysphoria and, indeed, for many people, it is the only effective treatment. *See, e.g.*, Pfäfflin & Junge 1998; Smith et al. 2005; Jarolím et al. 2009.

45. WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all support surgery in accordance with the SOC as medically necessary treatment for individuals with severe Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) (“For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role.”); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing “the efficacy, benefit and medical necessity of gender transition treatments” and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

46. Surgeries are considered “effective” from a medical perspective if they “have a therapeutic effect.” *See* Monstrey et al. 2007. More than three decades of research confirms that gender-affirming surgery is therapeutic and therefore an effective treatment for Gender Dysphoria.

47. In a 1998 meta-analysis, Pfäfflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded that “reassignment procedures were effective in relieving Gender Dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes” *See* Pfäfflin & Junge 1998.

48. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in The Netherlands concluded that after gender-affirming surgery there was “a virtual absence of gender dysphoria” in the cohort and “results substantiate previous conclusions that sex reassignment is effective” *See* Smith et al. 2005. Indeed, the authors of the study concluded that the surgery “appeared therapeutic and beneficial” across a wide spectrum of factors and “[t]he main symptom for which the patients had requested treatment, Gender Dysphoria, had decreased to such a degree that it had disappeared.”

49. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: “Summarizing the results from the 18 outcome studies of the last two decades, the conclusion that [gender-affirming surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare.”

50. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for Gender Dysphoria. For example, a 2001 study published in

Sweden states: “The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases” *See* Landen 2001. Similarly, urologists at the University Hospital in Prague, Czech Republic, in a *Journal of Sexual Medicine* article concluded, “Surgical conversion of the genitalia is a safe and important phase of the treatment of male-to-female transsexuals” *See* Jarolím 2009.

51. Patient satisfaction is an important measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of Gender Dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe Gender Dysphoria, gender-affirming surgery improves virtually every facet of a patient’s life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009); and greater acceptance and integration into the family (Lobato et al. 2006).

52. Studies have also shown that surgery improves patients’ abilities to initiate and maintain intimate relationships (Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al. 2009; Klein & Gorzalka 2009; Jarolím et al. 2009; Smith et al. 2005; Rehman et al. 1999; De Cuypere et al. 2005).

53. Multiple long term studies have confirmed these results. *See, e.g.*, “Transsexualism in Serbia: a twenty-year follow-up study” (Vujovic et al. 2009); “Long-term assessment of the physical, mental, and sexual health among transsexual women” (Weyers et al. 2009); “Treatment follow-up of transsexual patients” (Hepp et al. 2002); “A five-year follow-up study of Swedish adults with gender identity disorder” (Johansson et al. 2010); “A report from a single institute’s 14

year experience in treatment of male-to-female transsexuals” (Imbimbo et al. 2009); ‘Followup of sex reassignment surgery in transsexuals: a Brazilian cohort” (Lobato et al. 2006).

54. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that surgery is a medically necessary, not experimental, treatment for severe Gender Dysphoria as demonstrated by its inclusion as a medically necessary treatment in the SOC.

55. In 2008, WPATH issued a “Medical Necessity Statement” expressly stating: “These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient.”

56. Similarly, Resolution 122 (A-08) of the American Medical Association states: “Health experts in GID, including WPATH, have rejected the myth that these treatments are ‘cosmetic’ or ‘experimental’ and have recognized that these treatments can provide safe and effective treatment for a serious health condition.”

57. On September 25, 2013 the Department of Health Care Services of the State of California Health and Human Services Agency issues All Plan Letter 13-011, which makes clear that gender confirmation surgery was a covered service for Medi-Cal beneficiaries when the surgery was not cosmetic in nature and referred providers to the WPATH Standards of Care for the “criteria for the medical necessity of transgender services.” Illinois recently joined the states that will provide gender confirmation surgery for Medicaid recipients. *See* <https://www.chicagotribune.com/business/ct-biz-medicaid-gender-reassignment-surgery-20190405-story.html>.

58. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the

Board determined that a Medicare regulation denying coverage of “all transsexual surgery as a treatment for transsexualism” was not valid under the “reasonableness standard.” The Board specifically concluded that “transsexual surgery is an effective treatment option for transsexualism in appropriate cases.”

D. Living Consistently with Gender Identity

59. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender Dysphoria, like many medical conditions, often requires more than a single intervention for effective treatment. For example, clothing and grooming that affirm one’s gender identity, such as bras for transgender females, and the use of congruent pronouns are critically important components of treatment protocols. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

60. The SOC also specifically provide that permanent body hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating Gender Dysphoria for transgender women. Other gender-appropriate grooming items for transgender women such as feminine deodorant, moisturizer, and make-up may also be necessary for treatment. Similarly, male grooming items are important components of social role transition for transgender men. These accoutrements are critical to the mental well-being and social transition of gender dysphoric people.

61. “Mis-gendering”—the act or referring to a transgender person by the incorrect gender—is harmful to the mental health of transgender persons. It threatens their identity and can exacerbate the mental health problems attendant to Gender Dysphoria. It is therefore important, especially for those charged with the medical treatment and mental health care of transgender persons with Gender Dysphoria, to refer to transgender people using gender-affirming names and pronouns. (Bauer et al. 2015; Frost et al. 2015; Bockting 2014.)

62. Gender dysphoric prisoners are at heightened risk. In addition to the concerns outlined above, it is important for correctional facilities to consider appropriate housing and shower/bathroom facilities for transgender individuals. Each individual's gender identity and role, dignity, and personal safety should be taken into account in housing and other assignments. *See* SOC at 68. If the institution fails to do so, there can be serious consequences for mental and physical health. (Seelman, 2016.)

63. The act of showering with a person of a different gender or being subject to a pat-down or even strip search by an officer of a different gender can be a frightening and demeaning experience for transgender individuals. For those suffering from Gender Dysphoria, the experience can exacerbate their condition and lead to serious mental health complications, including worsening depression, anxiety, and hopelessness.

64. Moreover, transgender inmates who are housed in a facility that does not match their gender identity may be subject to increased instances of physical and sexual assault by other inmates and officers.

65. Clothing and grooming items are particularly important to provide to transgender patients with Gender Dysphoria who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender women, female undergarments allow testicles to be tucked and less visible, reducing symptoms of gender dysphoria. Likewise, regardless of breast development, a bra may be an important and affirming symbol of femininity for gender dysphoric women. Similarly, transgender men should be provided with male undergarments and male clothing.

66. Transgender individuals in the correctional environment sometimes are disciplined for attempts at grooming that effectively amount to self-treatment of their Gender Dysphoria. For example, transgender women may be disciplined for tattooing makeup, modifying their clothing to fit their preferred gender, or for wearing a ponytail.

67. Social role transition—including, for example, transgender women appearing feminine—has an enormous impact in the treatment of Gender Dysphoria. An early seminal study emphasized the importance of aligning presentation and identity and its benefits to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals who had socially transitioned with those who had not. Those who had implemented a social transition showed “a notable absence of psychopathology” compared to those who were presenting in their birth-assigned sex role. *See* Greenberg & Laurence 1981. In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one’s gender identity.

E. Risks of Providing Inadequate Care

68. Without adequate treatment, adults with Gender Dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently “defective.” This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. Many gender dysphoric women without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the removal of one’s testicles) in the hopes of eliminating the major source of testosterone that kindles the dysphoria. Brown & McDuffie 2009. (Brown, 2010.) A recent survey

found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

69. Gender dysphoria intensifies with age. As cortisol rises with normal aging, the ratio of DHEA to cortisol is affected, which acts to alter brain chemistry and intensify gender dysphoria. With the passage of time, inmates who require surgical treatment will experience greater distress, and no means of relief. *See* Ettner 2013; Ettner & Wiley 2013. This is particularly deleterious for transgender inmates serving long sentences.

70. Because Gender Dysphoria entails clinically significant and persistent feeling of stress and discomfort with one's assigned gender, if it is not treated, those feelings of stress and discomfort will increase and may become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without treatment, these individuals may not be capable of accomplishing simple everyday tasks, and may become increasingly socially withdrawn and isolated, which only serves to further exacerbate their symptoms.

71. Gender Dysphoria left untreated or inadequately treated, will result in serious harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. SOC at 67. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. Bauer 2015.

72. Moreover, gender dysphoric individuals have a profound discomfort with their genitalia. Without effective treatment as outlined above, this often leads to attempts at auto-castration, which can result in lasting physical trauma or even death in more serious cases. *See* Brown & McDuffie 2009.

73. In sum, the results of providing inadequate treatment are predictable and dire, and take one of three paths: profound psychological decompensation, surgical self-treatment, or suicide.

V. DEFICIENCIES IN THE TREATMENT FOR GENDER DYSPHORIA IDOC HAS PROVIDED TO THE NAMED PLAINTIFFS

74. I assessed whether the treatment provided to the named class representatives in this case by IDOC was appropriate, and below identify and describe deficiencies in that treatment and instances where the treatment deviated from the accepted standards set forth in the SOC. To undertake this analysis, I reviewed the named plaintiffs' medical records as kept by IDOC and the meeting minutes from IDOC's "Gender Identity Disorder Committee," or Transgender Committee, through which all treatment decisions for Gender Dysphoria are routed. I conducted in-person interviews, including a psychological evaluation and administration of psychological tests, for each named plaintiff in this matter in May 2018.

75. My analysis revealed that each of the named plaintiffs in this case is receiving treatment for Gender Dysphoria that deviates significantly from the well-accepted standards in the SOC, and that falls well below providing competent care. At bottom, none of the plaintiffs' Gender Dysphoria is being adequately treated. This means they continue to suffer unnecessarily, and also that they are at heightened risk of self-harm or suicide. There are commonalities among the deficiencies in care among the named plaintiffs, including: failure to timely initiated hormone therapy; failure to timely provide social transition, including through gender-affirming clothing and/or grooming items; and failure to evaluate plaintiffs for gender-affirming surgery.

A. Janiah Monroe

Review of IDOC Medical and GID Committee Records

76. Ms. Monroe is a 29-year-old transgender person currently incarcerated in Logan Correctional Center. She has identified as a female since a very young age, from the time she was a child living in the South Side of Chicago. Her family, and particularly her father, was hostile toward her female gender identity expression. Although she was never treated by a physician or other healthcare provider for Gender Dysphoria prior to entering IDOC, she took hormones when she could get access to them, and she informed IDOC of her status as a transgender female upon entering custody.

77. Ms. Monroe was diagnosed with Gender Dysphoria by an IDOC mental healthcare provider in November of 2011. This was only after she complained of symptoms of Gender Dysphoria for years to IDOC staff, including severe depression and hopelessness. Ms. Monroe's history of self-harm, suicidal ideation, and attempted suicide is well-documented in her IDOC records. She has attempted auto-castration and tried to commit suicide on multiple occasions. She described several different methods for attempting to commit suicide to me during our interview. The clinical term for attempted suicide by varying methods is called "method-switching," and it is a strong indicator that the person is likely to carry out a successful suicide in the future.

78. The GID Committee notes regarding Ms. Monroe acknowledge her history of Gender Dysphoria, documenting that she was diagnosed with dysphoria by an IDOC mental health professional in 2011. The Committee also acknowledges Ms. Monroe's suicide attempts and attempts at auto-castration. After Ms. Monroe requested hormone therapy to treat her diagnosed Gender Dysphoria, the GID Committee met in March of 2012 to discuss her case. Those records indicate that, despite her diagnosis and despite IDOC's own mental health professional opining

that hormone therapy should be considered, the Committee denied her hormone treatment. The Committee's only rationale was that if Ms. Monroe were to start hormone treatment, others might "follow [her] lead." The Committee met again in April of 2012 to discuss Ms. Monroe, and again denied her request for hormone therapy. The next available Committee records, from June 2015, indicate that Ms. Monroe was approved for hormone therapy at some point between April and June in 2012. Likewise, her medical records show that she began receiving cross-sex hormones sometime in mid-2012, after the Committee denied the therapy at least twice.

In-Person Interview and Psychological Examination

79. I administered an in-person psychological exam to Ms. Monroe on May 11, 2018 at Dixon Correctional Center, designed to measure her levels of anxiety, depression, and hopelessness. On the exam, Ms. Monroe demonstrated moderate levels of anxiety. On depression and hopelessness, which are the strongest predictors of whether a person will commit suicide, she scored extremely high. On hopelessness, she scored above a range at which a patient will normally go on to complete suicide.

80. Ms. Monroe showed no evidence of psychosis. It is my opinion that her severe mental health issues—namely, her depression and feelings of hopelessness—stem from her Gender Dysphoria, which roughly 8 years after her initial diagnosis by IDOC is still not being adequately treated. Ms. Monroe indicated that she would like to have gender-affirming surgery to treat her Gender Dysphoria. IDOC grievance records reflect that she has made formal requests for surgery, but that she has not even been evaluated, much less seriously considered, for such treatment. The reason, according to IDOC, is that "there is no policy in place" to provide surgery. Despite acknowledging that fact, the records also indicate that Ms. Monroe previously was denied

transfer to an all-female facility because she has not had gender-affirming surgery performed. I understand that Ms. Monroe recently was transferred to a female facility.

Deficiencies in Treatment and Related Risks

81. Ms. Monroe's treatment falls far outside of the WPATH guidelines and standards of care for gender dysphoric persons, and IDOC personnel have routinely ignored her serious medical needs.

82. The long delay in authorizing hormone treatment for Ms. Monroe is inexcusable and without any legitimate medical basis. The GID Committee records indicate treatment initially was denied because IDOC feared others would follow Ms. Monroe's lead. This is not a medically recognized or clinically appropriate reason, under WPATH guidelines or in my professional experience as a psychotherapist specializing in treatment of Gender Dysphoria, to deny hormone treatment to a gender dysphoric individual. This excuse does not even purport to relate to a medical concern.

83. Moreover, based on my years of practice, research, and clinical expertise, people do not request hormone therapy unless they actually need it and believe it would help them overcome their Gender Dysphoria. There are no secondary gains to treatment with cross-sex hormones; and in fact, when they are used incorrectly, or used in the absence of a legitimate medical need, they can be harmful. A hormone therapy regimen in a non-transgender person would make that person ill and profoundly uncomfortable.

84. IDOC records show that Ms. Monroe repeatedly has been denied gender-appropriate clothing and grooming items. Without access to such items, she is unable to transition socially and her Gender Dysphoria is likely to be severely exacerbated. Without effective treatment of her persistent and worsening Gender Dysphoria, including but not limited to gender-

affirming surgery, it is my professional clinical opinion that Ms. Monroe is likely to commit suicide as a result of her symptoms and IDOC's mismanagement of her condition.

85. It is my understanding that on April 1, 2019, Ms. Monroe was transferred to Logan Correctional Facility, a correctional center housing women. This was a necessary step in facilitating her social role transition and will help alleviate the severe mental health symptoms she experiences from Gender Dysphoria. However, unless she receives the other necessary treatment, including ongoing and appropriate hormone therapy and gender-affirming surgery, she will continue to be at serious and immediate risk of self-harm and possible suicide.

B. Sora Kuykendall

Review of IDOC Medical and GID Committee Records

86. Ms. Kuykendall is a 26-year-old transgender female currently incarcerated in Menard Correctional Center. She first identified as a female at around 5 years of age. She told her family, but her brother treated her badly and bullied her for her female mannerisms, and she began hiding her gender identity. Her family did not provide her with any medical or mental health support, so she was never evaluated for hormones or any other treatment as a child or adolescent. Her feelings of depression and hopelessness increased as she reached puberty and her body began to change in ways she did not recognize and that were not consistent with her gender identity.

87. Ms. Kuykendall informed an IDOC mental health professional of her transgender identity when she entered IDOC custody in November of 2014. In December 2014, she requested hormones, and a mental health treatment plan from January 2015 indicates that she would "[b]egin transitioning process from male to female." A mental health progress note from February 2015 noted that Ms. Kuykendall was experiencing depression as a result of Gender Dysphoria. Since being incarcerated, she has attempted auto-castration.

88. The GID Committee met in February 2015 to discuss Ms. Kuykendall, and acknowledged her Gender Dysphoria diagnosis, her history of self-harm, and her request for treatment.

89. Ms. Kuykendall began receiving hormones on February 27, 2015. However, her records indicate that she continued to experience serious symptoms of Gender Dysphoria. In June 2015, she requested gender-affirming surgery and gender-appropriate clothing items. She also complained repeatedly of strip searches by male officers, and requested that her searches be conducted by female officers only.

90. In January and February 2017, she continued to make many of the same requests of mental health professionals in the prison, including requests for feminine grooming products, gender-appropriate clothing, and gender-affirming surgery. She renewed her request for surgery as recently as August of 2017. There is no record that she has been evaluated or otherwise considered by IDOC as a candidate for surgery.

In-Person Interview and Psychological Examination

91. I conducted an in-person evaluation of Ms. Kuykendall on May 22, 2018 at Menard Correctional Center. Ms. Kuykendall presents as self-aware and intelligent, with feminine physical characteristics. While she is happy to be on hormones and she believes they help her mood, she exhibits symptoms of severe anatomical dysphoria, which is confirmed by her acts of self-harm and attempts at auto-castration. On the psychological tests I administered, she exhibited extremely high anxiety and had high suicidal ideation. Her depression and feelings of hopelessness both measured at clinically significant levels.

92. Because of Ms. Kuykendall's discomfort around male inmates and correctional officers, she almost never leaves her cell, and she resides by herself. This self-imposed solitary

confinement has been harmful to her emotional well-being. She appears to be exceptionally pale and rarely showers.

Deficiencies in Treatment and Related Risks

93. Ms. Kuykendall's self-imposed solitary confinement is related to her Gender Dysphoria and the extreme discomfort she experiences around men, particularly during searches of her person by male correctional officers. Her clinically significant hopelessness and depression, and her high levels of anxiety, are all symptoms of her underlying Gender Dysphoria.

94. Ms. Kuykendall likely requires gender-affirming surgery, and should be evaluated for such surgery immediately. As of my meeting with her in May 2018, she met all the diagnostic criteria for surgery. As long as evaluation for surgery is delayed, Ms. Kuykendall will continue to be at serious risk for self-harm and suicide, and will continue to experience feelings of hopelessness, depression and anxiety.

C. Sasha Reed

Review of IDOC Medical and GID Committee Records

95. Ms. Reed is a 26-year-old female currently incarcerated in Lawrence Correctional Center. She identified starting at around 11 years old, but did not receive any mental health or medical treatment relating to transgender issues. Ms. Reed reported her transgender status and her desire for treatment to an IDOC mental health professional in November of 2015. She reported that prior to her incarceration, she had been dressing as a female. Her medical records indicate a history of self-harm and attempted suicide.

96. The GID Committee met on December 18, 2015 and, despite Ms. Reed's history and indications of related mental health issues, the Committee determined that she did not meet the criteria for Gender Dysphoria and denied her treatment, including denial of hormone therapy.

The Committee met next on February 19, 2016, and denied Ms. Reed therapy again. The Committee stated that rather than recommending hormones, it needed to “clearly rule out a psychotic process and investigate offender’s conceptualization of gender identity.”

97. Throughout 2016, Ms. Reed’s records show she continued to report symptoms of mental distress attendant to her Gender Dysphoria. She also repeatedly requested hormone therapy and gender-appropriate clothing, and reported depression to mental health professionals. GID Committee records from a meeting in November 2016 show that the committee again denied hormone therapy for Ms. Reed’s Gender Dysphoria, citing as the basis for denial mental health issues generally.

98. In December 2016, Ms. Reed filed a grievance for gender-affirming surgery and gender-appropriate clothing and grooming items, which was denied as “moot.” The denial deferred entirely to the “Transgender Care Committee,” providing no further rationale for the denial.

99. The Committee finally approved Ms. Reed for hormone therapy in March of 2017, well over a year after she first requested treatment.

In-Person Interview and Psychological Examination

100. I conducted an in-person evaluation of Ms. Reed on May 23, 2018 at Lawrenceville Correctional Center. She exhibited severe levels of depression on the tests I administered. In our interview, Ms. Reed described symptoms consistent with Gender Dysphoria that first manifested in childhood. She also expressed a desire for female grooming items that she was not receiving, including body-hair removal items and makeup. She reported extreme distress resulting from being strip-searched by men at Lawrenceville.

Deficiencies in Treatment and Related Risks

101. The delay in initiating hormone treatment in Ms. Reed was inexcusable, and the Committee's stated reasons for the delay have no basis whatsoever in the Guidelines. It is unclear what the committee meant when it wrote that it must "investigate offender's conceptualization of gender identity," but that is not a medically valid reason to deny treatment.

102. The Committee provided no specific evidence that Ms. Reed's mental health issues were not well-managed, and I did not identify any such evidence in my own review of Ms. Reed's medical records. Indeed, mental health professionals were actively prescribing her Zoloft, Sertraline, and Loxitane to alleviate her purported mental health issues. In my in-person evaluation of Ms. Reed in May 2018, I noted no indication of any psychosis, and it is my clinical opinion that her mental health symptoms are a result of her Gender Dysphoria, not the result of a "psychotic process."

103. Ms. Reed has repeatedly requested gender-affirming surgery and the records indicate that IDOC has consistently ignored or denied those requests. But she appears to meet the criteria for surgery, and should be evaluated immediately. If IDOC continues to ignore her requests, her Gender Dysphoria will persist and worsen, and Ms. Reed will remain at serious risk of self-harm and suicide.

D. Lydia Helena Vision

Review of IDOC Medical and GID Committee Records

104. Ms. Vision is a 39 year-old transgender female currently incarcerated in Graham Correctional Center. She identified as a female from a very young age, but her family did not support her gender identity. Around the age of 8 or 9, she attempted auto castration. Because of her family's lack of support, she suppressed her gender identity for many years afterward. Ms.

Vision informed IDOC as early as January 2015 that she was transgender. She told mental health professionals that she felt incapable of fully expressing her feminine side due to her environment in the prison and her past experiences of being stigmatized for her female characteristics.

105. The GID Committee met on March 18, 2016, and noted that Ms. Vision was “mentally stable per MHP opinion.” Providing a short overview of Ms. Vision’s medical history, the Committee noted that she identified as female for the previous 8 years and had been diagnosed with Gender Dysphoria by an IDOC psychiatrist.

106. Despite acknowledging her diagnosis of Gender Dysphoria, the Committee nevertheless denied her hormone therapy, stating that her Gender Dysphoria “may not fully manifest itself in the correctional environment.” The Committee further noted, without elaboration, that it had concerns regarding her purported anger and aggression that “can be tied to PTSD.” The Committee also repeatedly referred to Ms. Vision as “he,” despite her identification as a female.

107. Ms. Vision continued to request hormones and gender-appropriate clothing and grooming items in 2016. The Committee met again in November of 2016 and again denied Ms. Vision hormone therapy. While still acknowledging her diagnosis of Gender Dysphoria, the Committee remained fixated on Ms. Vision’s purported PTSD, indicating that she had admitted to being sexually abused as a child. The Committee wrote that it was concerned about the “potential for further victimization and isolation as the physical effects of feminizing hormones become apparent.” The Committee did not explain the basis of its conclusion that Ms. Vision suffered from PTSD, nor elaborate on that diagnosis in any material way.

108. Ms. Vision’s records show that after this Committee meeting, she continued to report increased depression and anxiety as a result of not being approved for hormone therapy.

The Committee met again in March of 2017. They acknowledged Ms. Vision's requests for female undergarments, feminine grooming supplies, and hormones, and continued to deny her treatment. The only explanation provided was that the Committee had "concerns about [Ms. Vision's] mental health and capacity to undergo the physiologic changes associated with feminizing hormones in an environment where she has little to no support."

109. Ms. Vision's records indicate she began receiving them around November of 2018, representing a delay of over 2 years after she first requested treatment for Gender Dysphoria.

In-Person Interview and Psychological Examination

110. My psychological evaluation of Ms. Vision revealed no clinically significant indicators of psychological symptomology of post-traumatic stress disorder (PTSD): she scored low on the tests I administered for anxiety, depression and feelings of hopelessness. She has also developed effective coping mechanisms, such as working out and reading, and has successfully implemented various self-improvement techniques while incarcerated. For example, she earned a college degree in prison.

111. Despite her excellent coping skills, she also fits the criteria for persistent and early-onset Gender Dysphoria. She does not feel "at home" in her own body, and she had attempted auto-castration at a very young age. During my evaluation, I administered a test to Ms. Vision designed to diagnose PTSD, and she does not have the disorder. One of the Committee's primary justifications for repeatedly delaying hormone therapy for Ms. Vision was her supposed PTSD, a condition that the members of the Committee did not even attempt to diagnose in person.

Deficiencies in Treatment and Related Risks

112. Even if Ms. Vision did suffer from PTSD, it was not a legitimate reason to delay or defer treatment for Gender Dysphoria. Chronic PTSD is persistent and is unlikely to resolve, even

with therapy and prescription drugs. None of the records explain why Ms. Vision's supposed PTSD should act as a contraindication to hormone therapy or other relief.

113. Given her severe and persistent anatomical Gender Dysphoria, Ms. Vision should be evaluated for gender-affirming surgery when she becomes eligible in November 2019. Failure to do so will put Ms. Vision at serious risk of self-harm, and amounts to effectively ignoring her serious medical needs.

E. Marilyn Melendez

Review of IDOC Medical and GID Committee Records

114. Ms. Melendez is a 24-year-old transgender woman currently incarcerated in Pontiac Correctional Center. She identified as a female from a young age, and only her mother was supportive of her gender identity. Ms. Melendez did not receive formal medical treatment or counseling for transgender issues, but she took cross-sex hormones on occasions, whenever her mother was able to provide them to her. She entered IDOC custody as a juvenile at the age of 14.

115. Ms. Melendez informed IDOC of her transgender status and began seeking hormone therapy as early as February of 2015. She began discussing feelings of depression and other issues with IDOC healthcare professionals and was diagnosed with Gender Dysphoria on March 6, 2015. An IDOC mental health professional recommended she be referred to the GID Committee for potential hormone therapy.

116. The Committee met on March 27, 2015 and acknowledged Ms. Melendez's history of living as a female and feeling as if she was in the "wrong body." The Committee nevertheless denied hormone therapy, stating only that Ms. Melendez "need[ed] counseling on real life situations of living as opposite gender."

117. Ms. Melendez promptly filed a grievance relating to the denial of her hormone therapy. That grievance was denied, and the denial deferred entirely to the GID Committee, without any further reasoning or explanation. The Committee ultimately approved hormone therapy in July of 2015, after a 4-month delay.

118. Ms. Melendez requested access to a bra in March of 2016, which IDOC did not approve until a full year later. Ms. Melendez also requested gender-affirming surgery in October of 2016. Her records indicate that IDOC refused that request and has not even evaluated her as a candidate for such surgery.

In-Person Interview and Psychological Examination

119. At our interview on May 25, 2018 at Pontiac Correctional Center, Ms. Melendez presented as intelligent, articulate, and self-assured. However, Ms. Melendez also has a history of attempted suicide. On the psychological tests I administered, she exhibited clinically significant anxiety and depression, and extremely high feelings of hopelessness with suicidal ideation.

120. Ms. Melendez expressed a strong feeling that she hated her male genitalia and wanted them removed. Her Gender Dysphoria has persisted despite the initiation of hormone therapy, and in fact is becoming more severe. Ms. Melendez also reported to me that she still had not received a bra from IDOC that fits her properly.

Deficiencies in Treatment and Related Risks

121. The 4-month delay in initiating hormone therapy for Ms. Melendez was without any legitimate medical basis. The Committee's stated reason for delay—that she needed “counseling on real life situations of living as opposite gender”—is not a rationale for denying therapy, nor should such a factor even play into a decision about whether to initiate hormones. It is not clear from the records that such “counseling” was ultimately provided to Ms. Melendez.

122. The mental symptoms that Ms. Melendez continues to exhibit—in particular her extreme feelings of hopelessness and suicidal ideation—are symptoms of her Gender Dysphoria, which is worsening without effective treatment. It is also important for gender dysphoric individuals to have the appropriate clothing and grooming items that affirm their genders. As with hormone treatment, there was no legitimate medical basis to deny Ms. Melendez a bra for a year after she was diagnosed by an IDOC mental health professional with Gender Dysphoria.

123. Further, Ms. Melendez exhibits severe anatomical dysphoria and spoke of hating her male genitalia. She meets the criteria for gender-affirming surgery and should be evaluated immediately for surgery.

124. It is my opinion that IDOC's failure to evaluate Ms. Melendez for surgery, its unjustified delay in initiating hormone therapy, and its unjustified delay in providing her with a bra have all needlessly exacerbated her already-severe Gender Dysphoria. As long as she continues to have requests for gender-affirming clothing and surgery denied, and as long as the pattern of ignoring or delaying her requests continues, Ms. Melendez will remain in severe mental distress and at risk of suicide.

F. Putative Class Members

125. In my review of the medical records and GID Committee records relevant to the class members, I observed many of the same deficiencies in treatment that I have discussed above regarding the named plaintiffs.

126. Many of the class member inmates have been diagnosed with Gender Dysphoria, but have hormone treatment arbitrarily or unreasonably withheld by the GID Committee. The unnecessary denial or delay of hormone therapy can have severe consequences to the mental health of gender dysphoric patients. Without effective treatment, the course of Gender Dysphoria leads

to one of three outcomes in patients: psychological decompensation, surgical self-treatment (such as auto-castration in transgender women), or suicide.

127. The Committee's reasons for denial of treatment vary, but in all cases I reviewed, their reasons were not recognized under the WPATH Standards for denying or delaying treatment, and were not medically sound. One of the most fundamental errors repeatedly made by the Committee is to confuse the symptoms of Gender Dysphoria with having a co-occurring mental illness, and then denying treatment for a lack of "stability" or the need to address prior "trauma" before treatment can commence. Other times, the Committee denies treatment simply because there has been no IDOC psychiatric evaluation of the putative class member.

128. One of the minimum criteria for treating Gender Dysphoria is the ability to "recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria." SOC at 22. The Committee, which has no contact with the patient, lacks the necessary information to make this determination—and in any event its members do not have the specialized training to make this critical distinction. Relatedly, the Committee misunderstands or misapplies the requirement that co-occurring conditions be "reasonably well-controlled." Absent a psychotic break, or a patient so delusional as to be unable to consent to the treatment plan, treatment for Gender Dysphoria almost always should promptly follow a diagnosis. It is expected that "trauma" will present in most gender dysphoric patients, and by no means should be weaponized as a reason to deny treatment. Relatedly, the Committee misunderstands and mischaracterizes self-injurious behavior as something other than a manifestation of Gender Dysphoria—when a specialist in the field would understand that behavior to be a symptom showing that the condition is untreated or poorly treated.

129. Additional common examples of inappropriate rationales for denial and delay that appeared repeatedly in the records of the putative class members include: need for historical corroboration of gender incongruence beyond the patient's medical records; the patient's disciplinary history; the patient's need for "community support" or the need for more "real-life experience" living as a transgender individual; and "sexual potency." None of these justifications have a basis in the SOC, and competent practitioners would not deny or delay treatment on these bases. The Committee routinely takes into account these and other irrelevant factors in rendering a treatment decision.

130. In some cases, the Committee improperly discounted a putative class member's claim of transgender status or Gender Dysphoria diagnosis because the person had only recently disclosed to IDOC that they were transgender, or because the Committee believes the individual is "confused," "faking," or seeking some kind of "secondary gain." The Committee overlooks or does not understand that transgender individuals often experience tremendous fear about revealing or displaying gender non-conformance. This is especially true in the correctional setting, and many of these putative class members' records indicate that transgender inmates are afraid of other inmates and correctional officers. The Committee also ignores the fact that Gender Dysphoria can have a late onset and intensifies with age. The skepticism with which IDOC approaches Gender Dysphoria is completely unfounded: it is virtually unheard of that a patient who is not gender dysphoric will seek treatment.

131. The Committee's decisions to deny treatment often include denial of requests for gender-appropriate clothing or grooming items. While the Committee has approved the use of bras in gender dysphoric women—albeit typically only after they have taken hormones and exhibited breast development—the Committee does not approve other items, including underwear,

gender-appropriate soaps, shampoos, and deodorants, makeup and cosmetic items, or hair removal. This is contrary to the Standards of Care and deprives prisoners the social transition that the medical community recognizes as medically necessary.

132. None of the Committee records I examined authorized or recommended a medical evaluation of a putative class member for gender-affirming surgery, despite the fact that many transgender inmates requested such surgery. I understand that IDOC never has provided gender-affirming surgery. The records suggest an ignorance on the part of IDOC officials of the fact that gender-affirming surgery may be a medically necessary treatment for Gender Dysphoria. Based on my review of the records in this case, IDOC, through the GID Committee and the actions of its health care professionals, maintains a de facto policy of summarily denying access to gender-affirming surgery, even in cases where it would be indicated as a medically necessary treatment.

133. Overall, the reasons for denying or delaying treatment, when given, may not even reflect medical judgments: they are often administrative decisions made by a deliberative body that provides minimal or cursory explanations regarding their decisions, which have the effect of depriving transgender individuals with serious medical needs of much-needed treatment. For example, there is no indication in the Committee notes that the Committee considered or even reviewed the medical administration records of the individual inmates before rendering decisions (and often denying hormone treatment or asserting that an individual is not gender dysphoric).

134. Further, the members of the Committee seemingly are not qualified to treat transgender patients with Gender Dysphoria. In response to an interrogatory asking for their qualifications to treat Gender Dysphoria, the Defendants responded that four past and present members of the Committee (Melvin Hinton, Steven Meeks, William Puga, and Louis Shicker) are either licensed clinical psychologists or licensed physicians and surgeons. *See Resp. to*

Interrog. 5. As discussed above, the WPATH Standards provide certain minimum criteria that healthcare providers should have before treating gender dysphoric patients. Simply being a licensed clinical psychologist or a licensed physician does not make a person qualified to practice this specialized area of medicine. The Committee repeatedly makes fundamental and egregious errors that qualified practitioners would not make. The Committee notes on their face demonstrate fundamental lack of knowledge about Gender Dysphoria. Patients are sometimes mis-gendered by the Committee, and rarely if ever referred to by their gender-consistent name. The Committee sometimes uses the term “transgenders,” to refer to transgender people generally, which is an offensive term. Similarly, the records sometimes use the term “gender identification disorder,” which has never been a term accepted by healthcare professionals to refer to Gender Dysphoria.

135. Similarly, IDOC’s mental health professionals who directly treat gender dysphoric prisoners appear to lack the qualifications to do so. While I understand that those individuals have masters or doctorate level degrees, I have seen no indication that they have specific training and expertise in gender dysphoria. All indications, based on the care decisions I have seen, are that they do not. In fact, medical notes reflect that many practitioners do not even know the name of the condition—sometimes calling it “tg [transgender] disorder” and “sex dysphoria,” among other names that never have been accepted in medical literature. These same practitioners routinely refer to their own patients with incorrect names and pronouns.

136. The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct directs psychologists to “provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence” The Code of Ethics goes on to direct psychologists as follows: “Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with ... gender

[and] gender identity ... is essential for effective implementation of their services or research, psychologists have or obtain the training, experience consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals...”

137. Relatedly, the SOC state that in an institutional setting, “[i]f the in-house expertise of health professionals ... does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.” SOC at 67. I understand that IDOC has not engaged outside specialists to advise the Committee or to evaluate specific gender dysphoric patients.

138. Despite lacking qualifications to diagnose and treat Gender Dysphoria, the records show that the Committee will often second-guess, ignore, or overrule a diagnosis of Gender Dysphoria by another health care professional. This is not accepted practice. *See, e.g.*, Principles of Medical Ethics, American Psychiatric Association, § 7.3 (2013). Mental health professionals should exercise caution in diagnosing individuals without having carefully reviewed all pertinent and available medical records and conducted an in-person evaluation, tasks that are not undertaken in the case of the Committee members’ ad hoc diagnoses of and treatment decisions for transgender inmates.

139. Taken together, the records in this case form a clear pattern: IDOC, through the GID Committee, fundamentally misunderstands the serious medical condition of Gender Dysphoria, and lacks expertise and understanding to provide effective care. The care that is provided falls well outside the range of acceptable treatment, and puts patients’ health in serious danger.

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

Dated: April 24, 2019

Dr. Randi Ettner, Ph.D.

Dr. Randi Ettner, Ph.D.

APPENDIX A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

- 2016-present Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
Consultant: Walgreens; Tawani Enterprises
Private practitioner
- 2011 Instructor, Prescott College: Gender-A multidimensional approach
- 2000 Instructor, Illinois Professional School of Psychology
- 1995-present Supervision of clinicians in counseling gender non conforming clients
- 1993 Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
- 1992 Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
- 1983-1984 Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
- 1981-1984 Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
- 1976-1978 Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1975-1977 Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1971 Research Associate, Department of Psychology, Indiana University
- 1970-1972 Teaching Assistant in Experimental and Introductory Psychology
Department of Psychology, Indiana University
- 1969-1971 Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018
The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017,

Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; Care of the aging transgender patient-University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World

Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychoneuroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transmen. *Journal of Child and Adolescent Psychiatry*.

Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2018) A survey study of surgeons' experience with regret and reversal of gender-confirmation surgeries as a basis for a multidisciplinary approach to a rare but significant clinical occurrence, submitted.

Ettner, R. Mental health evaluation. *Clinics in Plastic Surgery*. (2018) Elsevier, 45(3): 307-311.

Ettner, R. Etiology of gender dysphoria in Schechter (Ed.) *Gender Confirmation Surgery: Principles and Techniques for an Emerging Field*. Elsevier, 2017.

Ettner, R. Pre-operative evaluation in Schechter (Ed.) Surgical Management of the Transgender Patient. Elsevier, 2017.

Berli, J., Kudnson, G., Fraser, L., Tangpricha, V., Ettner, R., et al. Gender Confirmation Surgery: what surgeons need to know when providing care for transgender individuals. *JAMA Surgery*; 2017.

Ettner, R., Ettner, F. & White, T. Choosing a surgeon: an exploratory study of factors influencing the selection of a gender affirmation surgeon. *Transgender Health*, 1(1), 2016.

Ettner, R. & Guillamon, A. Theories of the etiology of transgender identity. In Principles of Transgender Medicine and Surgery. Ettner, Monstrey & Coleman (Eds.), 2nd edition; Routledge, June, 2016.

Ettner, R., Monstrey, S. & Coleman, E. (Eds.) Principles of Transgender Medicine and Surgery, 2nd edition; Routledge, June, 2016.

Bockting, W, Coleman, E., Deutsch, M., Guillamon, A., Meyer, I., Meyer, W., Reisner, S., Sevelius, J. & Ettner, R. Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology and Diabetes*, 2016.

Ettner, R. Children with transgender parents in Sage Encyclopedia of Psychology and Gender. Nadal (Ed.) Sage Publications, 2017

Ettner, R. Surgical treatments for the transgender population in Lesbian, Gay, Bisexual, Transgender, and Intersex Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care. Ehrenfeld & Eckstrand, (Eds.) Springer: MA, 2016.

Ettner, R. Etiopathogenetic hypothesis on transsexualism in Management of Gender Identity Dysphoria: A Multidisciplinary Approach to Transsexualism. Trombetta, Liguori, Bertolotto, (Eds.) Springer: Italy, 2015.

Ettner, R. Care of the elderly transgender patient. *Current Opinion in Endocrinology and Diabetes*, 2013, Vol. 20(6), 580-584.

Ettner, R., and Wylie, K. Psychological and social adjustment in older transsexual people. *Maturitas*, March, 2013, Vol. 74, (3), 226-229.

Ettner, R., Ettner, F. and White, T. Secrecy and the pathophysiology of hypertension. *International Journal of Family Medicine* 2012, Vol. 2012.

Ettner, R. Psychotherapy in Voice and Communication Therapy for the Transgender/Transsexual Client: A Comprehensive Clinical Guide. Adler, Hirsch, Mordaunt, (Eds.) Plural Press, 2012.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., Adler, R., Brown, G., Devor, A., Ehrbar, R., Ettner, R., et.al. Standards of Care for the health of transsexual, transgender, and gender-nonconforming people. World Professional Association for Transgender Health (WPATH). 2012.

Ettner, R., White, T., and Brown, G. Family and systems aggression towards therapists. *International Journal of Transgenderism*, Vol. 12, 2010.

Ettner, R. The etiology of transsexualism in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.). Routledge Press, 2007.

Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Principles of Transgender Medicine and Surgery. Routledge Press, 2007.

Monstrey, S. De Cuypere, G. and Ettner, R. Surgery: General principles in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Routledge Press, 2007.

Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium*, 31-32.

Ettner, R. Transsexual Couples: A qualitative evaluation of atypical partner preferences. *International Journal of Transgenderism*, Vol. 10, 2007.

White, T. and Ettner, R. Adaptation and adjustment in children of transsexual parents. *European Journal of Child and Adolescent Psychiatry*, 2007: 16(4)215-221.

Ettner, R. Sexual and gender identity disorders in Diseases and Disorders, Vol. 3, Brown Reference, London, 2006.

Ettner, R., White, T., Brown, G., and Shah, B. Client aggression towards therapists: Is it more or less likely with transgendered clients? *International Journal of Transgenderism*, Vol. 9(2), 2006.

Ettner, R. and White, T. in Transgender Subjectives: A Clinician's Guide Haworth Medical Press, Leli (Ed.) 2004.

White, T. and Ettner, R. Disclosure, risks, and protective factors for children whose parents are undergoing a gender transition. *Journal of Gay and Lesbian Psychotherapy*, Vol. 8, 2004.

Witten, T., Benestad, L., Berger, L., Ekins, R., Ettner, R., Harima, K. Transgender and Transsexuality. Encyclopeida of Sex and Gender. Springer, Ember, & Ember (Eds.) Stonewall, Scotland, 2004.

Ettner, R. Book reviews. *Archives of Sexual Behavior*, April, 2002.

Ettner, R. Gender Loving Care: A Guide to Counseling Gender Variant Clients. WW Norton, 2000.

“Social and Psychological Issues of Aging in Transsexuals,” proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

“The Role of Psychological Tests in Forensic Settings,” *Chicago Daily Law Bulletin*, 1997.

Confessions of a Gender Defender: A Psychologist’s Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

“Post-traumatic Stress Disorder,” *Chicago Daily Law Bulletin*, 1995.

“Compensation for Mental Injury,” *Chicago Daily Law Bulletin*, 1994.

“Workshop Model for the Inclusion and Treatment of the Families of Transsexuals,” Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

“Transsexualism- The Phenotypic Variable,” Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

“The Work of Worrying: Emotional Preparation for Labor,” Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality,
University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award
Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

BIBLIOGRAPHY

Ainsworth, T. & Spiegel, J. (2010) Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research*, 19(7), 1019–24.

American Medical Association. (2008). *Resolution 122 (A-08), Removing Financial Barriers to Care for Transgender Patients*.

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. Washington, D.C.: American Psychiatric Publishing.

American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*. Washington, D.C.: American Psychiatric Publishing.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Washington, D.C.: American Psychiatric Publishing.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Washington, D.C.: American Psychiatric Publishing.

American Psychiatric Association, *Gender Dysphoria* (2013), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>.

Bao, A.M. & Swabb, D.F. (2011). Sexual differentiation of the human brain: Relation to gender identity, sexual orientation and neuro-psychiatric disorders, *Frontiers in Neurology*, 32(2), 214–26.

Bauer, G., Scheim, A., Pyne, J. *et al.* (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15:525.

Bennet, K., Qi, J., Kim, H., Hamill, J. *et al.* (2018). Comparison of 2-year complication rates among common techniques for post-mastectomy breast reconstruction. *JAMA Surgery*.

Bentz, E.K., Hefler, L.A., Kaufman, U. *et al.* (2008). A polymorphism of the CYP17 gene related to sex steroid metabolism is associated with female-to-male but not male-to-female transsexualism. *Fertility and Sterility*, 90(1), 56–59.

Berli, J., Kudnson, G., Fraser, L., Tangpricha, V., Ettner, R., *et al.* (2017). Gender Confirmation Surgery: what surgeons need to know when providing care for transgender individuals. *JAMA Surgery*, 152(4), 394–400.

Bockting, W. (2013). Transgender identity development. In Tolman & Diamond (Eds.), *American Psychological Association's Handbook of Sexuality and Psychology*. Washington, D.C.: American Psychological Association.

Bockting, W. (2014). The impact of stigma on transgender identity development and mental health. In Kreukels, Steensma, and De Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in care and knowledge*. New York: Springer.

Brown, G. (2010) Auto-castration and auto-penectomy as surgical self-treatment in incarcerated persons with Gender Identity Disorder. *International Journal of Transgenderism*, 12: 31-39.

Brown, G. & McDuffie, E. (2009) Health care policies addressing transgender inmates in prison systems in the US. *Journal of Correctional Health*.

Chung, W., De Vries, G., Swaab, D. (2002). Sexual differentiation of the bed nucleus of the stria terminalis in humans may extend into adulthood. *Journal of Neuroscience*, 22(3), 1027–33.

Cohen-Kettenis, P.T. and Gooren, L.J.G. (1993). The influence of hormone treatment on psychological functioning of transsexuals. *Journal of Psychology and Human Sexuality*, 1993(4), 55–67.

Colborn, T. Dumanoski, D. & Meyers, W. (1997). *Our Stolen Future*. New York: Penguin.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J. ... Zucker, K. (2011). WPATH Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.

Colizzi, M. , Costa, R., & Todarello, O. (2014). Transsexual patients' psychiatric comorbidity and positive effect on cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*, 39: 65-73.

Devor, A. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy*, 8(1-2), 41–67.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., et al. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior*, 34(6), 679–90.

Diamond, M. (2013). Transsexuality among twins: identity concordance, transition, rearing, and orientation. *International Journal of Transgenderism*, 14(1), 24–38.

Diamond, L., Pardo, S., Butterworth, M. (2011). Transgender experience and identity. In Schwartz *et al.* (Eds.), *Handbook of Identity Theory and Research*. New York: Springer.

Edgerton, M.T., and Meyer, J. K. (1973). Surgical and psychiatric aspects of transsexualism. In Horton, C. (Ed.), *Surgery of the External Genitalia* (pp. 117–61). Boston: Little, Brown.

Erickson, E. (1956). The problem of ego identity. *Journal of the American Psychoanalytic Association*, 4(1), 56–121.

Ettner, R. (1999). *Gender Loving Care*. New York: Norton.

Ettner, R. (2007) The etiology of transsexualism. In Ettner, R., Monstrey, S. & Eyler, A. (Eds.) *Principles of Transgender Medicine and Surgery* (pp. 1-14). New York: Haworth.

Ettner, R., Ettner, F. & White, T. (2012). Secrecy and the pathophysiology of hypertension. *International Journal of Family Medicine*, 2012.

Ettner, R. Care of the elderly transgender patient. *Current Opinion in Endocrinology and Diabetes*, 2013, 20(6), 580-584.

Ettner, R. & Wylie, K. (2013) Psychological and social adjustment in older transsexual people. *Maturitas*, 74(3), 226–29.

Ettner, R. (2015). Etiopathogenetic hypothesis on transsexualism. In Trombetta, Luguori & Bertolotto (Eds.) *Management of Gender Identity Dysphoria: A Multidimensional Approach to Transsexualism* (pp. 47–54). Italy: Springer.

Ettner, R. (2016). Surgical treatments for the transgender population. In Eckstrand, K. & Ehrenfeld, J. (Eds.) *Lesbian, Gay, Bisexual and Transgender Health Care*. (pp. 363–77). New York: Springer.

Ettner, R. & Guillamon, A. (2016). Theories of the etiology of transgenderism. In Ettner R., Monstrey, S. & Coleman E. (Eds.). *Principles of Transgender Medicine and Surgery* (pp. 3–15). New York: Routledge.

Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of Transgender Medicine and Surgery* (1st ed.). New York: Routledge.

Ettner, R. Monstrey, S., & Coleman, E. (Eds.) (2017). *Principles of Transgender Medicine and Surgery* (2nd ed.). New York: Routledge.

Fernandez, R, Esteva, I, Gomez-Gil, E., Rumbo, T., Almaraz, MC., Roda, E., Haro-

Mora, J.J., Guillamon, A., & Pasaro, E. (2014a). Association study of *ERb*, *AR*, and *CYP19A1* genes and MtF transsexualism. *Journal of Sexual Medicine*, *11*(12), 2986–94.

Fernandez, R., Esteva, I., Gomez-Gil, E., Rumbo, T. *et al.* (2014b) The (CA) in polymorphism of *ERb* gene is associated with FtM transsexualism. *Journal of Sexual Medicine*, *11*(3), 720–28.

Frost, D., Lehavot, K., & Meyer, I. (2015). Minority stress and physical health among sexual minority individuals. *Journal of Behavioral Medicine*. *Journal Behavioral Medicine*, *38*(1), 1–8.

Galis, F., Ten Broek, C., Van Dongen, S., *et al.* (2010). Sexual dimorphism in the prenatal digit ratio (2D:4D). *Archives of Sexual Behavior*, *39*(1), 57–62.

Garcia-Falgueras, A. & Swaab, D (2008). A sex difference in the hypothalamic uncinate nucleus: relationship to gender identity. *Brain*, *131*(12), 3132–46.

Garcia-Falgueras, A. & Swaab, D (2010). Sexual hormones and the brain: As essential alliance for sexual identity and sexual orientation. *Pediatric Neuroendocrinology*, *17*, 22–35.

Garn, S., Bundi, A., Babler, W., *et al.* (1975). Early prenatal attainment of adult metacarpal-phalangeal rankings and proportions. *American Journal of Physical Anthropology*, *43*, 327–32.

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges. *Annual Review of Sex Research*, *18*(1), 178–224.

Goffman, E. (1969). *The Presentation of Self in Everyday Life*. London: Allen Lane.

Gomez-Gil, E., Esteva, I., Almaraz, M.C. *et al.* (2010). Familiarity of gender identity disorder in non-twin siblings. *Archives of Sexual Behavior*, *39*(2), 265–69.

Gomez-Gil, E., Zubiaurre-Elorza, L., Esteva, I., Guillamon, A. *et al.* (2012). Hormone-treated transsexuals report less social distress, anxiety and depression. *Psychoneuroendocrinology*, *37*(5), 662–70.

Gooren, L.J. (2011). Care of transsexual persons. *New England Journal of Medicine*, *364*, 1251–57.

Gorin-Lazard, A., Baumstark, K., Boyer, L., Maguigneau, A., *et al.* (2012). Is hormonal therapy associated with better quality of life in transsexuals? A cross-sectional study. *Journal of Sexual Medicine*, *9*(2): 531–41.

- Green, R. (2000). Family co-occurrence of “gender dysphoria”: Ten siblings or parent-child pairs. *Archives of Sexual Behavior, 29*(5), 499–507.
- Greenberg, R. & Laurence, L. (1981). A comparison of MMPI results for psychiatric patients and male applicants for transsexual surgery. *Journal of Nervous and Mental Disease, 169*(5), 320–23.
- Guillamon, A., Junque, C., & Gomez-Gil, E. (2016). A Review of the status of brain structure research in transsexualism. *Archives of Sexual Behavior, 45*(7), 1615–48.
- Haas, A. et al. (2014). *Suicide Attempts among Transgender and Gender Non-Conforming Adults*, <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>.
- Halim, M.L., & Ruble, D. (2010). Gender identity and stereotyping in early and middle childhood. In Chrisler, J.C. & McCreary, D.R. (Eds.), *Handbook of gender research in psychology* (Vol. 1, pp. 495–526). New York: Springer.
- Hare, L., Bernard, P., Sanchez, F. et al. (2009). Androgen receptor length polymorphism associated with male-to-female transsexualism. *Biological Psychiatry, 65*(1), 93–96.
- Hatzenbuehler, M., Bellatorre, A., Lee, Y., et al. (2014). Structural stigma and all-cause mortality in sexual minority populations. *Social Science & Medicine, 103*; 333–41.
- Henningsson, S., Westberg, L, Nilsson, S. et al. (2005). Sex steroid-related genes and male-to-female transsexualism. *Psychoneuroendocrinology, 30*(7), 657–64.
- Hines, M. (2011). Gender development and the human brain. *Annual Review of Neuroscience 34*, 69-88.
- Jarolím, L., Šedý, J., Schmidt, M., Ondřej, N., Foltán, R., & Kawaciuk, I. (2009). Gender reassignment surgery in male-to-female transsexualism: A retrospective 3-month follow-up study with anatomical remarks. *Journal of Sexual Medicine, 6*, 1635–44.
- Kerlin, S. (2004). The presence of gender dysphoria, transsexualism, and disorders of sex differentiation in males prenatally exposed to diethylstilbestrol: initial evidence from a 5-year study. DES Sons International network. TransAdvocate.org.
- Kruijver, F.P. et al. (2000), Male-to-female transsexual have female neuron numbers in a limbic nucleus. *Journal of Clinical Endocrinology & Metabolism, 5*(1), 2034–41.
- Landen, M. et al. (2001). Done is done – and gone is gone: Sex reassignment surgery is presently the best cure for transsexuals. *Lakartidningen, 98*(30-31), 3322–26.

Landen, M. et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PloS One*, 6(2): e16885.

Lawrence, A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior*, 32(4), 299–315.

Lobato, M., Koff, W., Manenti, C., Seger, D. et al. (2006). A follow-up of sex reassignment surgery in transsexuals: A Brazilian cohort. *Archives of Sexual Behavior*, 35(6), 711–15.

Longo, M., Azanon, E. & Haggard, P. (2010). More than skin deep: Body representation beyond primary somatosensory cortex. *Neuropsychologia*, 48(3), 665–68.

Luders, E., Narr, K., Thompson, P., Rex, D. et al. (2006). Gender effects on cortical thickness and the influence of scaling. *Human Brain Mapping*, 27(4), 314–24.

Manning, J., Fink, B. Neave, N. et al. (1998). The ratio of 2nd to 4th digit length, a predictor of sperm numbers and concentrations of testosterone, luteinizing hormone and oestrogen. *Human Reproduction*, 13, 3000-04.

Marique, O., Odabi, K., Martinez-Jorge, J., Ciudad, P., et al (2018) Complications and patient-reported outcomes in male-to-female vaginoplasty-where we are today: A systematic review and meta-analysis. *Annals of Plastic Surgery* 80(6): 684-91.

Miranda, R., Scott, M., Hicks, R., Wilcox, H., Munfakh, J.L.H., & Shaffer, D. (2008). Suicide attempt characteristics, diagnoses, and future attempts: Comparing multiple attempters to single attempters and ideators. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(1), 32–40.

Nuttbrock, L, Rosenblum, A. & Blumenstein, R. (2002). Transgender identity affirmation and mental health. *International Journal of Transgenderism*, 6(4).

Phelps, V. (1952). Relative index finger as a sex-influenced trait in man. *American Journal of Human Genetics*, 4, 72-89.

Pfäfflin, F., & Junge, A. (1998). *Sex reassignment: Thirty years of international follow-up studies after sex reassignment surgery, a comprehensive review, 1961–1991* (Jacobson, R., & Meier, A., Trans.). Retrieved from <http://www.symposion.com/ijt/pfaefflin/1000.htm> (Original work published 1992).

Rehman, J., Lazar, S., Benet, A., Schaefer, L, & Melman, A. (1999). The reported sex and surgery satisfaction of 20 postoperative male-to female transsexual patients. *Archives of Sexual Behavior*, 28(1), 71–89.

Rametti, G., Carillo, B., Gomez-Gil, E., Junque, C. *et al.* (2011) White matter microstructure in female to male transsexuals before cross-sex hormonal treatment: A diffusion tensor imaging study. *Journal of Psychiatric Research*, 45(2), 199–204.

Rametti, G. *et al.* (2011). The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study, *Journal Psychiatric Research*, 45(7), 949–54.

Ruble, D., Taylor, L., Cyphers, L., Greulich, F., Lurye, L., Shrout, P. (2007). The role of gender constancy in early gender development. *Child Development* 78(4), 1121-1136.

Savic, I. & Arver, S. (2011). Sex dimorphism of the brain in male-to-female transsexuals. *Cerebral Cortex*, 23(11), 2855–62.

Schneider, H., Pickel, J., Stalla, G. (2006). Typical female 2nd-4th finger length (2D:4D) ratios in male-to-female transsexuals-possible implications for prenatal androgen exposure. *Psychoneuroendocrinology*, 31(2), 265–69.

Seelman, K. (2016). Transgender adults' access to college bathrooms and housing and the relationship to suicidality. *Social Work Faculty Publications*, 64.

Shaw, P., Kabani, N., Lerch, J., Eckstrand, K. *et al.* (2008). Neurodevelopmental trajectories of the human cerebral cortex. *Journal of Neuroscience*, 28(14), 3586–94.

Singh, A., Hays, D. & Watson, L.S. (2011). Strengths in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development*, 89(1), 20–27.

Smith, Y., van Goozen, S., Kuiper, A., & Cohen-Kettenis, P. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescents and adult transsexuals. *Psychological Medicine*, 35(1), 8999.

Steensma, T., Biemond, R., de Boer, F. & Cohen-Kettenis, P. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clinical Child Psychology and Psychiatry* 16(4), 499-516.

Steensma, T., McGuire, J., Kreukels, B., Beekman, A. & Cohen-Kettenis, P. (2013). Factors associated with desistance and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of American Academy of Child and Adolescent Psychiatry* 52(6), 582-590.

Steensma, T., van der Ende, J. Verhulst, F. & Cohen-Kettenis, P. (2013). Gender variance in childhood and sexual orientation in adulthood: A prospective study. *Journal of Sexual Medicine* 10(11), 2723-2733.

Taziaux, M., Swaab, D., Bakker, J. (2012). Sex differences in the neurokin B system in the human infundibular nucleus. *Journal of Clinical Endocrinology and Metabolism*, 97(12), 2010–20.

Wiepjes C., Nota N., de Blok C, et al. (2018) The Amsterdam Cohort of Gender Dysphoria Study: Trends in Prevalence, Treatment, and Regrets. *Journal of Sexual Medicine* 15:582-90

Weyers, S. *et al.* (2009). Long-term assessments of the physical, mental and sexual health among transsexual women. *Journal of Sexual Medicine*, 6(3), 752--60.

World Health Organization. (1992). International Classification of Diseases (10th ed.).

World Professional Association for Transgender Health, Inc. (2008). WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage U.S.A., <http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf>

Zhou, J., Hofman, M., Gooren, L. *et al.* (1995). A sex difference in the human brain and its relation to transsexuality. *Nature*, 378, 68–70.

Zubiaurre-Elorza, L., Junque, C., Gomez-Gil, E., Segovia, S., Carrillo, B., Rametti, G. & Guillamon, A. (2013). Cortical thickness in untreated transsexuals. *Cerebral Cortex* 23, 2855-62.

Zubiaurre-Elorza, L., Junque, C., Gomez-Gil, E., Segovia, S., Carrillo, B., Rametti, G. & Guillamon, A. (2013). Cortical thickness in untreated transsexuals. *Cerebral Cortex* 23, 2855-62.

Zubiaurre-Elorza, L., Junque, C., Gomez-Gil, E. & Guillamon, A. (2014). Effects of cross-sex hormone treatment on cortical thickness in transsexual individuals. *Journal of Sexual Medicine*, 11(5), 1248–61.