Paul Carlos Southwick (ISB No. 12439)
Emily Myrei Croston (ISB No. 12389)
ACLU of Idaho Foundation
P.O. Box 1897
Boise, ID 83701
Tel: (208) 344-9750
psouthwick@acluidaho.org
ecroston@acluidaho.org

Chase B. Strangio*
Malita Picasso*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad St.
New York, NY 10004
Tel: (212) 549-2584
cstrangio@aclu.org
mpicasso@aclu.org

*To be admitted *pro hac vice*

*Attorneys for Plaintiffs*

**UNITED STATES DISTRICT COURT**

**FOR THE DISTRICT OF IDAHO**

| | |
|---|---|
| **JANE ROE, JANE POE, JANE DOE**,<br>*Plaintiffs*,<br>v.<br>**RAÚL LABRADOR**, et al.,<br>*Defendants*. | Case No.<br><br>**DECLARATION OF RANDI C. ETTNER, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION** |

## I. INTRODUCTION

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I am the past Secretary of, and I served

as a member for more than 12 years on, the Board of Directors of the World Professional Association of Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have extensive experience treating transgender individuals with gender dysphoria in my clinical practice and have published numerous books and articles on the topic.

2. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

3. I have been retained by counsel for plaintiffs to provide the Court with my expert opinions regarding the treatment protocols for gender dysphoria and the harms of denying and/or discontinuing treatment for individuals who need and rely on that treatment. This report sets forth my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on the health and well-being of individuals living with gender dysphoria; (ii) information regarding best practices and the accepted standards of care for individuals with gender dysphoria; and (iii) the harms of denying or withdrawing medical treatment for individuals with gender dysphoria who have a medical need for such treatment.

## II. QUALIFICATIONS

4. 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.

5. During the course of my career, I have evaluated, diagnosed, and treated more than 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1977 to present.

6. 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; Routledge 2007) and the 2nd edition (co-editors Monstrey & Coleman; Routledge 2016). I am currently under contract for the 3rd edition of this text. In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of healthcare to the transgender population.

7. I have served as a member of the University of Chicago Gender Board, am on the editorial boards of *Transgender Health* and the *International Journal of Transgender Health* and am an author of the WPATH Standards of Care for the *Health of Transsexual, Transgender and Gender-Nonconforming People* (7th version), published in 2011. I am also an author of the WPATH Standards of Care Version 8, published in 2022, and chaired the chapter on Institutionalized Persons. WPATH is an international association of 4,500 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Institutionalized Persons and provide training to medical professionals on healthcare for transgender prisoners.

8. I am on the Medical Staff at Weiss Memorial Hospital in Chicago, and I have lectured throughout North America, Europe, South America, 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 Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017, I 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 United States House of Representatives on February 5, 2019, recognizing my work for WPATH and gender dysphoria in Illinois.

9. 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. 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. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *Shawntee Levy v. Robert Green*, et.al., No. TDC-18-1291(D. Md.); *Cordellione v. Indiana Dep't. of Corrs*, No. 3:23-cv-135 (S.D. In.); D.T. v. Christ, No. 4:20-cv-484-JAS (D. Ariz.). *Diamond v. Ward*, No. 5:20-

cv-00543 (M.D. Ga. 2022); *Stillwell v. Dwenger*, No. 1:21-cv-1452-JRS-MPB (S.D. Ind. 2022); *Letray v. Jefferson Cty.*, No. 20-cv-1194 (N.D.N.Y. 2022); *C.P. v. BCBSIL*, No. 3:20-cv-06145-RJB (W.D. Wash. 2022); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. 2021); *Iglesias v. Connor*, No. 3:19-cv-00415-NJR (S.D. Ill. 2021); *Monroe v. Jeffreys*, No. 3:18-CV-00156-NJR (S.D. Ill. 2021); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D. Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328 (M.D. Tenn. 2020); *Eller v. Prince George's Cty. Pub. Schs.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Gilbert v. Dell Technologies*, No. 19-cv-1938 (JGK) (S.D.N.Y. 2019); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *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).

11. 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**.

## III. COMPENSATION

12. My clinical consulting fee in this case is $400.00 per hour for any clinical services, records review, or report drafting in connection with this case; $550.00 per hour for any depositions or oral testimony in this case, and $2,500.00 per day for any

necessary travel in conjunction with this case. My compensation does not depend on the outcome of this case, the opinions I express, or the testimony I may provide.

## IV. MATERIALS CONSIDERED

13. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive clinical experience and my 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 in particular sections of this report.

## V. GENDER DYSPHORIA

14. 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.

15. At birth, infants are typically classified as male or female. This classification becomes the person's birth-assigned sex. Typically, persons born with the external physical characteristics associated with males psychologically identify as men, and persons born with the external physical characteristics associated with females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's gender—one's

gender identity—differs from the birth-assigned sex, giving rise to a sense of being "wrongly embodied."

16. 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 distress and discomfort with the gender they were identified as at birth (their "assigned gender" or "birth-assigned sex").

17. 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.

18. 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[.]").

19. There is broad scientific understanding that gender identity is biologically based and a significant body of scientific and medical research that gender dysphoria has a physiological and biological etiology (cause or origin).

20. 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. (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 (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 (2000).

21. 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.

Bao & Swaab (2011).

22. Similarly, Hare et al. found 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. at 93, 96.

23. Efforts to change a person's gender identity are unethical, harmful, and futile. Researchers have documented the risks and harms of attempting to coerce individuals to conform to their birth-assigned sex. These include, but are not limited to, the onset or increase of depression, suicidality, substance abuse, loss of relationships, family estrangement, and a range of post-traumatic responses. *See* Byne (2016); Green, et al. (2020); Turban, et al. (2019). Numerous professional

organizations have endorsed the Unites States Joint Statement Against Conversion Efforts, including the American Medical Association, The American Academy of Family Physicians, The American Psychological Association, The American Psychoanalytical Association, The World Professional Association for Transgender Health, and many other professional organizations. Several countries throughout the world, and states and municipalities in the Unites States, have enacted laws prohibiting health care professionals from engaging in conversion attempts.

24. In other words, stopping treatment for gender dysphoria or refusing to recognize a person's gender identity does not prevent them from being transgender, it merely increases their distress.

## VI. TREATMENT OF GENDER DYSPHORIA

### A. WPATH Standards of Care

25. Gender dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of gender dysphoria are currently set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (8th version, 2022). These recommendations are also mirrored in the Endocrine Society's clinical practice guideline: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline."

26. The WPATH promulgated Standards of Care ("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 treatment protocols in accordance with the SOC. *See, e.g.*, American Medical Association Resolution 122 (A-08) (2008); Hembree et al. (2009); American Psychological Association, *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009) ("APA Policy Statement"). In addition, numerous courts have recognized the Standards of Care promulgated by WPATH as authoritative.

27. Throughout this report, I make references to the 8th version of the SOC, with cites to that version referred to below in this report simply as "SOC."

28. As set out in the SOC, many transgender individuals with gender dysphoria undergo a medically indicated and supervised gender transition in order to ameliorate the debilitating distress of gender dysphoria. 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:

- Social transition, which may involve changes to gender expression and role, including adopting a different name, pronoun, external expression;
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics;
- Psychotherapy (individual, couple, family, or group) for 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.

29. 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. Custodial status is not a medical justification to deviate from accepted standards of care or medically necessary treatment for any medical condition, including gender dysphoria. An individual's custodial status, housing status, and/or security classification are not *medical* justifications to deny medically necessary care, including surgical care, for the treatment of gender dysphoria or any other medical condition that I am aware of. I am aware of no medical condition that requires deviation from accepted treatment protocols simply because a person is incarcerated and no treatment protocol that is rendered not medically necessary solely because the patient is incarcerated. For these reasons, the SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Chapter 11), 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 and Gender Diverse Health Care in Correctional Settings* (2020), https://www.ncchc.org/transgender-and-gender-diverse-health-care-in-correctional-settings-2020/.

30. Under the SOC, "All of the recommendations of the Standards of Care apply equally to people living in [institutional settings]. People should have access to these medically necessary treatments irrespective of their housing situation within an institution (Brown, 2009)." SOC at S104.

31. 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.

32. 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* SOC, Chapter 5. 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 field relevant to the role; 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; the ability to assess one's ability to consent to treatment; ability to liaise with professionals across disciplines; knowledge of gender nonconforming identities and expressions, the assessment and treatment of gender dysphoria; and, continuing education in the assessment and treatment of gender dysphoria. SOC at S32.

33. 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.

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

35. Notably, psychiatric medications are not efficacious in a treatment for gender dysphoria. In addition, while psychotherapy or counseling can provide support and help with the personal and social aspects of a gender transition and may to some extent lessen conditions such as depression and anxiety, psychotherapy and counseling cannot resolve underlying distress due to the incongruence between a person's gender identity and birth-assigned sex. There are no psychotherapeutic interventions that have been demonstrated to be effective in alleviating the gender dysphoria itself and such interventions 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.

36. For many individuals with gender dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called "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. *See, e.g.*, Greenberg & Laurence (1981); Ettner (1999); Devor (2004).

**B. Hormone Therapy**

37. 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. See SOC, Chapter 12.

38. 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 SOC is medically necessary treatment for many individuals with gender dysphoria. *See* AMA Resolution 122; Hembree et al. (2009); APA Policy Statement.

39. 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* Hembree et al. (2009).

40. 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 receptor 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).

41. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormone therapy 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. (2014); Gorin-Lazard et al. (2011).

42. Transgender women who have undergone gender-affirming orchiectomy or other gender-affirming genital surgeries resulting in removal of the testicles, must receive consistent gender-affirming hormone therapy at the appropriate therapeutic levels to avoid adverse health effects. Interruption of this essential treatment can result in a lack of lymphocyte production and impaired immunity, hypertension, hypoglycemia, depression, and electrolyte imbalance. Appropriate laboratory

monitoring of hormone therapy should occur every three months for the first year of treatment to validate the efficacy of treatment. Once stability is attained, laboratory monitoring can be done twice a year. Laboratory work should include tests for liver function, complete blood counts, lipid panel, and electrolyte values.

43. Over my years of practice, I have observed clinically the many psychological and physiological benefits of hormone therapy for patients with gender dysphoria. Individuals experience a previously unknown level of well-being when receiving hormonal treatment, and improvement is observable in virtually every area of a patient's life. It is not hyperbole to describe the impact of this medical treatment as "life-altering." The realization that one has lived as a "false self," through no fault of one's own, kindles a tectonic shift in mood, mental health and behavior. This is particularly dramatic in the case of incarcerated people. Having evaluated prisoners in 20 states and 49 institutions throughout the US, I have witnessed extraordinary transformations in patients who are provided with appropriate gender-affirming medical care. Depression, anxiety, suicidality and self-harm are often significantly reduced, or entirely eliminated. The increased self-esteem and improved emotional regulation often results in rehabilitation or parole suitability for these patients.

**C. Gender-Affirming Surgery**

44. For some individuals with severe gender dysphoria, hormone therapy alone is insufficient. For these individuals, relief from their dysphoria cannot be achieved without surgical intervention to modify primary and/or secondary sex characteristics, *i.e.*, genital reconstruction. Under the contemporary understanding

of gender identity, transition-related medical treatments confirm, rather than "change," an individual's sex by aligning primary and secondary sex characteristics with a person's gender identity. See generally, SOC, Chapter 13 (noting the clinical benefits of surgical intervention for those who need it); *see also Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.*, WPATH (Dec. 21, 2016).[1]

45. Gender-affirming genital surgery for transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, through gender-affirming genital surgery, the patient attains body congruence as a result of uro-genital structures appearing and to some extent functioning in ways that are more typical for non-transgender women. Both are critical in alleviating or eliminating gender dysphoria.

46. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgeries are safe and effective treatments for severe gender dysphoria and, indeed, for many people suffering from gender dysphoria, the only effective treatment. *See, e.g.*, Pfäfflin & Junge (1998); Smith et al. (2005); Jarolím et al. (2009).

[1] *https://www.wpath.org/newsroom/medical-necessity-statement* ("In some cases, [medical procedures attendant to gender affirming/confirming surgeries] [are] the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.") (emphasis in original).

47. In 2018, Cornell University published a literature review called *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?*[2] The researchers enumerated the following conclusions:

- The scholarly literature makes clear that gender transition is effective in treating gender dysphoria and can significantly improve the well-being of transgender individuals.
- Among the positive outcomes of gender transition and related medical treatments for transgender individuals are improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance use.
- The positive impact of gender transition on transgender well-being has grown considerably in recent years, as both surgical techniques and social support have improved.
- Regrets following gender transition are extremely rare and have become even rarer as both surgical techniques and social support have improved. Pooling data from numerous studies demonstrates a regret rate ranging from .3 percent to 3.8 percent. Regrets are most likely to result from a lack of social support after transition or poor surgical outcomes using older techniques.

[2] What We Know Project, Cornell University (2018), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/.

- Factors that are predictive of success in the treatment of gender dysphoria include adequate preparation and mental health support prior to treatment, proper follow-up care from knowledgeable providers, consistent family and social support, and high-quality surgical outcomes (when surgery is involved).
- Transgender individuals, particularly those who cannot access treatment for gender dysphoria or who encounter unsupportive social environments, are more likely than the general population to experience health challenges such as depression, anxiety, suicidality, and minority stress. While gender transition can mitigate these challenges, the health and well-being of transgender people can be harmed by stigmatizing and discriminatory treatment.

48. Studies conducted in countries throughout the world likewise conclude that gender-affirming 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 [gender-affirming] surgery in carefully selected cases." 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." Jarolím (2009).

49. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that such

surgery is a medically necessary, not experimental, treatment for severe gender dysphoria.

**D. Living Consistently with Gender Identity**

50. 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 pronouns congruent with an individual's gender identity are critically important components of treatment protocols. *See* Greenberg & Laurence (1981); Ettner (1999); Devor (2004).

51. "Misgendering"—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 exacerbates 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 to use the correct, gender-affirming names and pronouns for them. *See* Bauer et al. (2015); Frost et al. (2015); Bockting (2014).

52. Gender dysphoric prisoners are at heightened risk for depression, anxiety, suicidal ideation, and self-harm without appropriate treatment and care. 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. If the institution fails to do so, there can be serious consequences for mental and physical health. *See* Seelman (2016).

53. Gender consistent clothing and grooming items are particularly important to provide to transgender patients with gender dysphoria, especially for those individuals 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 genitals 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 transgender women.

54. Social role transition—the ability for a transgender person to appear and live consistent with their gender—has an enormous impact in the treatment of gender dysphoria. An early seminal study emphasized the importance of aligning gender presentation and identity and the benefits of doing so 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. Greenberg &

Laurence (1981). In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one's gender identity. More recently, Sevelius (2013) proposed a "gender affirmation model" which demonstrated that access to gender-affirming components of social role transition equated with better mental health, fewer suicide attempts, and lower levels of depression and posttraumatic stress disorder (PTSD) symptoms.

**E. Risks of Providing Inadequate Care**

55. 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) or auto-penectomy (the removal of one's penis). Brown & McDuffie (2009). A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline suicide attempt rates for North America. Mak et al. (2020).

56. Gender dysphoria intensifies with age. As cortisol (the body's "stress hormone") rises with normal aging, the ratio of dehydroepiandrosterone ("DHEA," a

precursor hormone involved in the production of sex hormones—testosterone and estrogen—which decreases with normal aging) to cortisol is affected, which acts to alter brain chemistry and intensify gender dysphoria. With the passage of time, prisoners 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 prisoners serving long sentences. Because gender dysphoria entails clinically significant and persistent feelings of distress and discomfort with one's assigned gender, if it is not treated, those feelings intensify with time and can become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without adequate, appropriate 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.

57. Gender dysphoria left untreated or inadequately treated, will result in serious psychological and physical harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. *See, e.g.*, Bauer (2015).

58. Moreover, gender dysphoric individuals have a profound discomfort or disgust of their genitalia. Without effective treatment as outlined above, this often leads to attempts at surgical self-treatment (SST), which can result in lasting physical trauma or death. *See* Brown & McDuffie (2009). Some incarcerated

individuals with severe, inadequately treated gender dysphoria have gone so far as to amputate their penis and flush it down a prison toilet as they experience blood loss and possible death from their auto-penectomy. It is also common for prisoners with severe, inadequately treated gender dysphoria to surreptitiously bind their penis in an attempt to sever it.

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

**F. Risks of Terminating Care.**

60. In addition to the risks outlined above, the potential risks of harm are more severe here than in most other cases because Idaho's law contemplates cutting prisoners off of treatment regardless of medical need. This could result in individuals losing care who have relied on that care for years or decades; individuals losing care who have had an orchiectomy and need hormone therapy in the absence of the body's endogenous production of hormones; individuals abruptly losing care without appropriate titration causing severe physiological consequences.

61. The SOC are clear that transgender "persons who enter an institution on an appropriate regimen of gender-affirming hormone therapy should be continued on the same or similar therapies and monitored according to the SOC Version 8." SOC at S106. For years prison systems in the United States implemented what were called "freeze frame" policies that maintained transgender prisoners on the level of treatment they were receiving at the time they were incarcerated. This prevented

individuals from initiating new treatments or increasing their hormone dosages based on medical need while in custody. These policies were uniformly condemned as medically unsound and ultimately illegal. What Idaho proposes is returning to a "freeze frame" paradigm but with even more deleterious effects because of the many people already relying on hormones who will lose access to that care on top of the increased dysphoria of preventing future treatment.

62. As the SOC recognize: "The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a significant likelihood of negative outcomes (Brown, 2010; Sundstrom and Fields v. Frank, 2011), such as surgical self-treatment by autocastration, depressed mood, increased gender dysphoria, and/or suicidality (Brown, 2010; Maruri, 2011)." SOC at S106. For patients currently undergoing hormone therapy, abrupt cessation of treatment can cause the body to enter a state of hormonal dysregulation. This can result in depressed mood, hot flashes, and headaches. For patients on spironolactone –a testosterone suppressant – abruptly terminating treatment can cause a patient's blood pressure to spike, increasing a person's risk of heart attack or stroke. The abrupt withdrawal of treatment also results in predictable and negative mental health consequences including heightened anxiety and depression.

## XI. CONCLUSION

63. There is broad consensus in the medical community that, for some individuals diagnosed with gender dysphoria, gender-affirming hormone therapy and surgery are medically necessary when other treatment is unlikely to alleviate the patient's symptoms, prevent further emotional and psychological pain, and prevent associated physical harm. This has long been recognized to be true in institutional settings and, over the last several decades, prison agencies in the United States have worked to ensure that prisoners with gender dysphoria are treated with appropriate medical care. Imposing a categorical ban on treatment that fails to account for a patient's individual medical needs will prove disastrous.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 27 day of June, 2024.

Dr. Randi Ettner, Ph.D.
Dr. Randi Ettner, Ph.D.