IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA, Plaintiff, RACHEL TUDOR, Plaintiff-Intervenor, v. SOUTHEASTERN OKLAHOMA STATE UNIVERSITY, and THE REGIONAL UNIVERSITY SYSTEM OF OKLAHOMA, Defendants.	**Case No. CIV-15-324-C**

DEFENDANTS' RESPONSE IN OBJECTION TO DR. TUDOR'S MOTION TO QUASH THE SUBPOENA ISSUED TO FELESHIA PORTER

Defendants, Southeastern Oklahoma State University, ("SEOSU"), and The Regional University System of Oklahoma ("RUSO"), (collectively " Defendants"), object to Plaintiff's Motion to Quash the Subpoena [Doc. 82-1] issued to Feleshia Porter, and request, for the reasons set forth below, that Plaintiff/Intervenor's motion be denied.

INTRODUCTION

Defendants have served Feleshia Porter with an Amended Deposition Notice and Subpoena to allow Defendants to obtain testimony specifically related to her April 4, 2007 Letter, which Plaintiff/Intervenor presented to SEOSU's Human Resources

Department in or around June 1, 2007.[1] (*Porter letter of April 4, 2007,* attached as Exhibit 1). Intervenor has moved to quash the notice and subpoena, solely on the grounds it seeks information protected by the psychotherapist-patient privilege. Intervenor ignores the fact that Defendants are seeking information that is not protected by the psychotherapist-patient privilege. In addition, to some extent, the psychotherapist-patient privilege must yield to permissible discovery, and lastly, Intervenor has waived any such privilege to the extent she intends to present testimony, and/or seek damages related to gender dysphoria, her mental distress, anguish or humiliation. Intervenor has further waived the psychotherapist-patient privilege as to questions of Ms. Porter regarding what information she was offering to divulge to Defendants, or any other person, as set forth in her April 4, 2007 Letter.

ARGUMENT AND AUTHORITY

The burden is on the moving party to establish entitlement to a protective order or show that a subpoena *duces tecum* should be quashed. *Howard v. Segway, Inc.*,2013 WL 869955 (N.D. Okla. 2012*)*, pp. 3-4, citing *Washington v. Thurgood Marshall Academy*, 230 F.R.D. 18, 21 (D.D.C. 2005); A party seeking to quash a subpoena has a particularly heavy burden, as contrasted with one who seeks only limited protection. *Howard* at *4,

[1] Defendants originally noticed Ms. Porter's deposition for Dallas for no other purpose than for the sole convenience of Ms. Porter. Thus, upon determining that Ms. Porter's deposition would not proceed on the designated date of July 26, 2016 due to Intervenor's Motion to Quash and Defendants' agreement to withdraw the subpoena, Defendants rescheduled the deposition for a later date, in Durant, OK, to allow the Motion to be timely and properly addressed. Unfortunately, due to the mileage requirements of Fed. R. Civ. P. 45, there was not a logical location within the Western District to schedule Ms. Porter's deposition, and thus, Defendants selected Durant, near SEOSU's campus.

citing *In re Coordinated Pretrial Proceedings in Petroleum Products Antitrust Litigation*, 669 F.2d 620, 623 (10th Cir. 1982). A party moving for a protective order must make a particularized showing of why all discovery should be denied, and conclusory or generalized statements in the motion fail to meet this burden. *Smith v. United Salt Co.*, No. 1:08CV00053, 2009 WL 2929343, at *5 (W.D. Va. 9 Sept. 2009). Plaintiff has failed to make any such particularized showing, especially in light of the fact that Ms. Porter can testify about many non-privileged topics.

I. DEFENDANTS ARE SEEKING NON-PRIVILEGED INFORMATION

Ms. Porter's April 4, 2007 Letter, addressed "To whom it may concern", contains various statements which Defendants are entitled to inquire about. It states that Rachel Tudor is undergoing psychological therapy, but contains no assertion that Ms. Porter is providing this therapy to Dr. Tudor, or that she is treating/counseling Dr. Tudor on any matter. Further, Ms. Porter states "Treatment requires the candidate to live full time as a woman prior to surgery." Defendants are entitled to inquire of Ms. Porter regarding this requirement, as discussed in more detail below. Porter also writes, "Therefore she should be treated with respect and afforded all the rights and privileges of a female." Again, Defendants should be entitled to question Ms. Porter about the meaning and purpose of this statement. Finally, she comments that she has "been working with the transgender community since 1997 and follows the guidelines set forth by the Harry Benjamin International Gender Dysphoric Association. For more information regarding gender transition you may contact me at the above numbers." Defendants should be permitted to

question Ms. Porter generally about gender dysphoria, including details of the disorder, diagnosis and treatment.

It was asserted in depositions that the administrators at SEOSU should have consulted Dr. Tudor's therapist, Feleshia Porter, regarding the matter of Intervenor's transition. For example, during the deposition of Cathy Conway, the following exchanges took place:

> Q. (by Allan Townsend, Plaintiff's counsel) Did you ever attempt to contact Feleshia Porter – the person that signed this letter [regarding Intervenor's gender transition]?
> A. No.
> Q. Do you know whether anyone at Southeastern ever attempted to contact Feleshia Porter?
> A. No.

(*Deposition of Cathy Conway*, attached as Exhibit 2, at p. 33, lns. 9–19);

> Q. (by Jillian Weiss, Intervenor's counsel) Okay. What steps did you take to learn more about transgender people after Dr. Tudor came out as a transgender woman?
> …
> Q. Did you call Dr. Feleshia Porter to speak with her?
> A. No.
> Q. And why would you not call Dr. Porter?
> . . .
> Q. Did you receive this letter from Dr. Tudor?
> …
> Q And did you read the letter?
> A. Yes, I did.
> Q. And looking at the second paragraph, the last sentence, it says, for more information regarding gender transition, you may contact me at the above numbers. Did I read that correctly?
> A. Yes.
> Q. And so what did you take that to mean?
> A. If I needed more specific information, I should call her.
> Q. And did you need more specific information?
> A. No.
> Q. And did you call Dr. Porter?

A. No.

(*Id.* at p. 127, lns. 19-21; p.129, lns. 2-5; lns. 15-25; p. 130, lns. 1-9).

Based upon these questions to Ms. Conway, it is clear that Intervenor contends Ms. Porter would have provided specific information to Cathy Conway regarding what actions she needed to take to assist Dr. Tudor during her transition. Defendants should be permitted, through the deposition of Ms. Porter, to glean this information. As both Plaintiff and Intervenor have put Ms. Porter's letter at issue, including her professional opinion, as well as any information and/or advice she would have provided, it is certainly appropriate to question her regarding the statements contained in her letter.

It is also appropriate to question Ms. Porter about "more information" she references with regard to contacting her. To the extent Ms. Porter is relying upon the medical records and other documentation pertaining to Tudor and/her psychological treatment, as a basis for her statements, Defendants should be allowed to question her regarding those documents as well.

Ms. Conway was also questioned about her knowledge regarding the length of time a transgender should wait before undergoing sex reassignment surgery, and the source of such knowledge. (Ex. 2, p. 139, lns. 3-25; p. 140, lns. 1-9). These questions were posed in such a manner to suggest Ms. Conway had no good faith or legitimate basis for her belief, and that she had acted inappropriately by not contacting Ms. Porter. Both Plaintiff and Intervenor Counsel found it appropriate to question Cathy Conway about Ms. Porter's letter, as well as rebuke her for not contacting Ms. Porter, thus clearly placing her letter, and related testimony, at issue.

II. PLAINTIFF'S CLAIMS MEAN THAT THE PSYCHOTHERAPIST-PATIENT PRIVILEGE MUST YIELD TO THE NEEDS OF DISCOVERY IN THIS CASE

Because a psychotherapist-patient privilege exists as to some of the information sought, Defendant must provide a basis for permitting the disclosure of medical records. *United States v. Carter*, 2014 WL 5469750, at *1 (W.D. Okla. Oct. 28, 2014). Intervenor contends Defendants have not provided an adequate basis for disclosure. However, the Tenth Circuit has held that "a plaintiff who relies on her mental condition as an element of her claim may not assert the psychotherapist-patient privilege to preclude a defendant from obtaining discovery of her mental health records." *LeFave v. Symbios, Inc.*, 2000 WL 1644154, at *4 (D. Colo. Apr. 14, 2000) (citing *Dixon v. City of Lawton, Okl.*, 898 F.2d 1443, 1451 (10th Cir. 1990)). To obtain records pertaining to mental health, the requesting party must demonstrate that the plaintiff "has placed her mental condition in controversy and there is good cause for production of the records." *Ortiz-Carballo v. Ellspermann*, 2009 WL 961131, at *2 (M.D. Fla. Apr. 7, 2009) (internal quotation marks omitted). A plaintiff will be deemed to have put his or her mental condition in controversy if she asserts "a claim of mental or psychiatric *injury*." *Peters v. Nelson*, 153 F.R.D. 635, 638 (N.D. Iowa 1994). Finally, courts have concluded that an emotional damages claim puts at issue a party's physical or mental medical condition:

> [T]his evidence is relevant to the issue of damages and, particularly, the extent to which, if any, [the person alleging discrimination] sustained emotional injuries. The EEOC made this issue material by seeking damages for emotional harm in its Complaint.

E.E.O.C. v. BCI Coca–Cola Bottling Co. of Los Angeles, 2008 WL 2229489, at *4 (D.N.M. Feb. 14, 2008); *see also Smith v. Nw. Fin. Acceptance, Inc.*, 129 F.3d 1408, 1417 (10th Cir.1997) (noting that "the testimony of a treating physician or psychologist ... is one suggested method of proving emotional damages"); *E.E.O.C. v. BCI Coca–Cola Bottling Co. of Los Angeles*, 2008 WL 2229489, at *4 (evidence of counseling is relevant to prove damages in claim where plaintiff alleged emotional harm.)

In the present case, the Complaint in Intervention [Doc. 24] asserts Defendants' actions constituted harassment and resulted in profound guilt and humiliation to Dr. Tudor, and thus, Intervenor seeks relief based upon such humiliation, loss of enjoyment of life, and loss of professional reputation. Intervenor contends Defendants caused Intervenor to suffer emotional distresses of humiliation and embarrassment for four (4) years, and that the work environment was permeated with discriminatory intimidation, ridicule, and insult, sufficiently severe or pervasive to alter her employment conditions and create an abusive working environment. [Doc 24, ¶¶ 53, 56, 57, 131, 135]. Intervenor has not offered any evidence or documentation of said emotional distress, nor has Intervenor offered any explanation as to why, over that four-year period, Intervenor never once complained or indicated discomfort with the situation allegedly created by Defendants. Because Intervenor has made a request for damages based on an alleged mental condition, Intervenor should be compelled to provide any and all records or other documentation in support of this claim. In addition, to the extent Ms. Porter is relying upon her notes and records or other documentation pertaining to Tudor and/her

psychological treatment, as a basis for her statements, Defendants should be allowed to question Ms. Porter regarding those documents as well.

As set forth previously regarding in the deposition testimony of Cathy Conway, both Plaintiff and Intervenor placed Ms. Porter's professional opinions at issue, and thus, it is certainly appropriate to disclose medical records and other documentation pertaining to the psychological treatment by Porter. Attached to Plaintiff-Intervenor's motion as Exhibit B is a declaration, in which Dr. Tudor states, "To my recollection, I received psychotherapy care from Ms. Porter in 2007 only" (Tudor Declaration, ¶3), "To my recollection I had two visits with Ms. Porter…" (*Id.*at ¶4), and "To my recollection, my treatment with Ms. Porter was narrowly focused on diagnosing me with a condition that is now called gender dysphoria." (*Id.* at ¶5), however, she also goes on to state "there were oral communications between myself and Ms. Porter regarding my psychological condition." (*Id.* at ¶6). Defendants should not be required to accept Dr. Tudor's recollection, which is completely unsupported by any documentation. Instead, Defendants are entitled to question Ms. Porter about these issues that Dr. Tudor has placed at issue in this litigation, as well as review related documents.

Counsel for both Plaintiff and Intervenor have put Ms. Porter's involvement at issue in this case, and presumably already have access to the records in question. Both Defendants should be afforded the same opportunity to review relevant records. In addition, although Dr. Tudor contends her treatment with Porter ended prior to her encountering the alleged hostilities, Defendants are entitled to discovery regarding her mental and emotional state prior to the actions alleged in this lawsuit.

a. Defendants are Entitled to Question Ms. Porter Regarding Gender Dysphoria

Finally, if Dr. Tudor or any other witness intends to testify about Dr. Tudor suffering from gender dysphoria, Defendants should be permitted to question Ms. Porter regarding her diagnosis and treatment of Dr. Tudor. Plaintiff's Complaint contains five paragraphs under the subtitle, "Sex and gender identity." [Doc.1, ¶¶ 65-69]. Paragraph 69 states, "Transgender individuals will often undertake some level of gender transition, which is the process of bringing external manifestations of their gender into conformity with their gender identity. A core aspect of gender transition is that individuals present themselves in the gender role that is consistent with their gender identity." Based upon the statements contained in her letter, Ms. Porter claims to be knowledgeable in this area, generally and specifically as to Dr. Tudor, and thus, Defendants are entitled to inquire into such knowledge in her deposition. If a privilege ever attached to Ms. Porter's treatment of Dr. Tudor, Dr. Tudor waived the privilege, at least in some degree, when she presented the letter to SEOSU which communicates Ms. Porter's willingness to provide further information, and later, when counsel repeatedly questioned SEOSU's witnesses regarding Ms. Porter's letter and their subsequent actions in response to the letter.

Plaintiff has designated Dr. George R. Brown as an expert in this case. Dr. Brown's Expert Report (attached as Exhibit 3), states he has been asked to render expert opinions in various areas, including (4) The condition of "gender dysphoria"(previously called gender identity disorder), and (5) Treatment of gender dysphoria and gender identity disorder. (Ex. 3, p. 2). None of Dr. Brown's opinions are specific to Tudor, but

instead relate to gender identity and gender dysphoria. Dr. Brown's report also sets out major diagnostic criteria for the diagnosis of gender dysphoria: "The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas as of functioning." In order to attach any relevance to this criteria, it would seem that evidence regarding such distress and/or impairment would be necessary. Yet, no such evidence has been produced.

Dr. Brown's report contains no mention of Dr. Tudor, and contains no explanation regarding what relevance, if any, his opinions have in this lawsuit. While the purpose or relevance of Dr. Brown's opinions is not clear, his report suggests Plaintiff and Intervenor intend to present evidence at trial of Dr. Tudor suffering from gender dysphoria, directly placing any diagnosis and /or treatment at issue. If so, Defendants are entitled to discovery on this issue, including what information, if any, Ms. Porter has on this subject. Dr. Tudor has not identified any other doctors, counselors or psychologists from whom she has received treatment, and thus, Defendants have no knowledge, other than the information contained in Ms. Porter's letter, of Dr. Tudor's treatment.

II. NO ACTION HAS BEEN TAKEN BY DEFENDANTS THAT WARRANTS SANCTIONS

Pursuant to 28 U.S.C. § 1927:

> Any attorney or other person admitted to conduct cases in any court of the United States or any Territory thereof who so multiplies the proceedings in any case unreasonably and vexatiously may be required by the court to satisfy personally the excess costs, expenses, and attorneys' fees reasonably incurred because of such conduct.

However, the Tenth Circuit has cautioned that this is an "extreme standard," and the imposition of attorney fees should be awarded "only in instances evidencing a serious and standard disregard for the orderly process of justice." *AeroTech, Inc. v. Estes*, 110 F.3d 1523, 1528 (10th Cir. 1997) (internal quotation marks omitted). Thus, courts must "strictly construe[ ]" the statute to guard against "dampen[ing] the legitimate zeal of an attorney in representing his client." *Braley v. Campbell*, 832 F.2d 1504, 1512 (10th Cir. 1987) (en banc). Although the Tenth Circuit does not require a finding of bad faith, it does require a finding that the conduct, when "viewed objectively, manifests either intentional or reckless disregard of the attorney's duties to the court." *Hamilton v. Boise Cascade Exp.*, 519 F.3d 1197, 1205 (10th Cir. 2008).

Intervenor's acerbic request for sanctions is inappropriate, inaccurate, and highly unprofessional. No conduct of Defendants' counsel was performed with any type of intentional or reckless disregard of duties to the Court, nor were any acts performed with any vexatious purpose. First, Defendant has not previously placed at issue Defendant's entitlement to depose Ms. Porter, nor to obtain specific information related to her April 4, 2007 letter. Second, Defendant was not required to wait on an unrelated ruling before pursuing, in a timely manner, discoverable testimony. Had Defendants waited for the Court to rule on pending discovery motions, they would have run the risk of not having sufficient time to comply with the Federal Rules regarding notice, as well as creating undue burden on all parties and counsel if compelled to notice the deposition on one of the last days of discovery. Finally, Intervenor omits to include in her brief that, prior to the Texas filings, Defendants' counsel informed Intervenor's counsel during a telephone

conversation that Defendants would agree to submit to the jurisdiction of this Court regarding this matter, so that the convoluted filings by Intervenor would not be necessary. As evidenced by Jillian Weiss' email exchange with Ms. Porter, at some point it was Intervenor's intent to file the motion to quash in this Court. [Doc.82-13, p. 77 of 144]. Defendants' counsel further indicated that if there was any question regarding the ability of this Court to address Intervenor's concerns and motion, Defendants would join with Intervenor in seeking guidance from this Court to avoid any procedural problems, and was willing to amend the notice, if necessary, to properly place the matter before the Court. (Counsel for Intervenor and Defendants agreed this Court was the proper Court to address this dispute, in light of the pending litigation.) Intervenor's counsel simply chose not to pursue this resolution. Further, the logical approach would have been to simply seek an agreement to postpone the deposition and production of documents pending resolution of the dispute, yet Intervenor never made such a request, instead proceeding with filing the motion and related documents in the Texas Court, and seeking a transfer.

Defendants' Amended Notice to take Deposition [Doc 77] was filed on July 28, 2016 at 10:19am, prior to the filing of Tudor's Notice of Order Issued in TX [Doc 80], (filed on July 28, 2016 at 5:18pm), and was not filed with any knowledge of an Order having been entered at approximately that same time in the Texas court. Nor was the Amended Notice issued for any inappropriate reason, but instead, to reschedule the deposition for a date sufficiently in the future to allow the Court adequate time to address Intervenor's Motion to Quash in the event the parties could not reach a resolution. As previously stated, the revised location of Durant, where SEOSU is located, was chosen

due to its convenience to Defendants' counsel and Defendants. Once again, counsel had discussions regarding the proposed deposition date and location, and Intervenor's objections to the notice and subpoena. Again, Defendants' counsel attempted to reach a resolution with Intervenor's counsel to allow Intervenor to submit the discovery dispute to this Court, rather than Intervenor having to follow the procedural technical requirements for a transfer (as Intervenor's counsel had stated he intended to request the transfer). Intervenor shunned Defendants' suggestion and proceeded with filing the motion in the Eastern District, and requested the matter be transferred.

Intervenor's accusations of "Defendants' mechinations" and "unreasonable and vexatious multiplication of proceedings" are simply inaccurate and out of place, as Intervenor is the only party that sought the involvement of all three courts, making no effort to reach a resolution to present the issue before this Court. Intervenor would not agree to present Ms. Porter for deposition in Oklahoma City (or Dallas), and therefore Defendants had to notice Ms. Porter for a location that fell within the Fed. R. Civ. P. 45 subpoena power.

Intervenor's reliance upon sanctions issued by this Court in *Cf. Resolution Trust Corp. v. Dabney*, 73 F.3d 262(10th Cir. 1995), is also misplaced. In the *Dabney* case, Plaintiff's counsel issued a subpoena *duces tecum* ordering defendants to produce all 500 title examinations performed by Defendant Dabney since 1975. The district court found the subpoena *duces tecum* sought discovery well after the discovery deadline and that it was interposed for purposes of harassment, unnecessary delay and increase in the cost of litigation. *Id.* at 269. None of these factors are present here. Defendants' deposition

notice and subpoena to Ms. Porter were issued in a timely manner, for the sole purpose of obtaining relevant discoverable evidence in case, as set forth above.

Intervenor's allegation of forum-shopping is meritless, and as described above, based upon an inaccurate recitation and omission of events. Further, in light of Intervenor's requests in both motions in to quash, to transfer the matter to this Court, Defendants had no reason to believe this discovery dispute would not ultimately be resolved here. Regardless of such belief though, Intervenor's unjustified attacks on Defendants for doing nothing more than legally attempting to obtain information they believe to be discoverable in this matter is unwarranted, as well as inappropriate. Intervenor's allegations of Defendants taxing the resources of three courts suggests Defendants somehow attempted to have multiple courts, at the same time, address the issue of Ms. Porter's deposition notice, which is simply not true, and is not supported by the pleadings.

CONCLUSION

For the reasons set forth above, Defendants respectfully request the Court deny Plaintiff/Intervenor's Motion to Quash the Subpoena to depose Feleshia Porter, and further deny Intervenor's request for sanctions.

Respectfully submitted,

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VERIFICATION OF COUNSEL

The above-signed counsel certifies that all statements regarding conversations with Plaintiff/Intervenor's counsel are true and correct as stated.

/s/Dixie L. Coffey
Dixie L. Coffey

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of August 2016, I electronically transmitted the foregoing document to the Clerk of the Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to the following ECF registrants:

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UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA, et al.	)	
Plaintiff,	)	
VS.	)	Civil Action No. 5:15-CV-00324-C
SOUTHEASTERN OKLAHOMA STATE UNIVERSITY, et al.	)	
Defendant.	)	

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ORAL DEPOSITION OF
CATHY CONWAY
MARCH 10, 2016

****

ORAL DEPOSITION OF CATHY CONWAY, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and -numbered cause on the 10th day of March, 2016, from 8:58 a.m. to 4:52 p.m., before Chrissa K. Mansfield-Hollingsworth, CSR in and for the State of Texas, reported by machine shorthand, at the offices of U.S. Attorney's Office, located at 600 East Taylor Street, Suite 2000, Sherman, Texas, pursuant to the Federal Rules of Civil Procedure.

Exhibit 2

Q. Do you -- did you understand from this letter that Dr. Tudor wanted to be treated as a woman?

MS. COFFEY: Object to form.

A. Yes.

Q. (By Mr. Townsend) Did you have any problem with that?

A. No.

MS. COFFEY: Object to form.

Q. (By Mr. Townsend) Did you ever attempt to contact Feleshia Porter --

MS. COFFEY: Object to form.

Q. (By Mr. Townsend) -- the person that signed this letter?

MS. COFFEY: Same objection.

A. No.

Q. (By Mr. Townsend) Do you know whether anyone at Southeastern ever attempted to contact Feleshia Porter?

A. No.

Q. Did you talk to your supervisor, Mr. -- or Dr. Walkup, about the information you received from Ms. Brown when she gave you this letter?

A. Probably at some point I did.

Q. You say probably. You're not sure whether you ever talked to him?

Exhibit 2

you understand it.

A. Could you repeat it, please?

Q. Yes. Is one of the purposes of sex reassignment surgery to ensure that transgender people can use the restroom that matches their gender identity?

MS. COFFEY: Same objection.

A. No, unless law requires it.

Q. (By Ms. Weiss) Unless law requires what?

A. If there was a law that required a surgery.

Q. Do you mean if there's a law that requires a surgery in order to use a bathroom?

A. No. Anyone can use a bathroom.

Q. Let me rephrase that. Laws that would dictate which sex uses which restrooms?

A. Yes.

Q. And are you aware of any such laws that govern Southeastern University?

A. No, not --

Q. Okay. What steps did you take to learn more about transgender people after Dr. Tudor came out as a transgender woman?

MS. COFFEY: Object to form.

A. I just sought advice from my general counsel.

Q. (By Ms. Weiss) Okay. Did you read any books on transgender issues?

Exhibit 2

A. No.

Q. (By Ms. Weiss) Did you call Dr. Feleshia Porter to speak with her?

A. No.

Q. And why would you not call Dr. Porter?

MS. COFFEY: Object to form.

Q. (By Ms. Weiss) Well, let me rephrase it and ask this way. Actually, let me first show you an exhibit. Okay. I'd like to show you Plaintiff's Exhibit 25. Do you recognize this exhibit?

A. Yes.

Q. And what is it?

A. It's a letter from Feleshia Porter regarding T.R. Tudor.

Q. Did you receive this letter from Dr. Tudor?

MS. COFFEY: Object to form.

Q. (By Ms. Weiss) How did you receive this letter?

A. One of my staff brought it to me.

Q. And did you read the letter?

A. Yes, I did.

Q. And looking at the second paragraph, the last sentence, it says, For more information regarding gender transition, you may contact me at the above numbers. Did I read that correctly?

Exhibit 2

A. Yes.
Q. And so what did you take that to mean?
A. If I needed more specific information, I should call her.
Q. Okay. And did you need more specific information?
A. No.
Q. And did you call Dr. Porter?
A. No.
Q. And what expertise does Mr. Babb have on transgender issues?
MS. COFFEY: Object to form.
Q. (By Ms. Weiss) Are you aware of any expertise that Mr. Babb has on transgender persons?
A. Yes.
Q. And what is that expertise as far as you're aware?
A. It was Tenth Circuit. It was a -- their position was in discussion in a related case in another circuit.
Q. And are you referring to a discussion that you had with Mr. Babb in mentioning what you just mentioned?
A. Yes.
Q. Okay. And so did you rely on Mr. Babb's discussion of that material to determine the appropriate

Exhibit 2

MS. COFFEY: Object to form.

A. No.

Q. (By Ms. Weiss) Okay. So in terms of -- sorry. Strike that. On this letter, Plaintiff's Exhibit 25, is there anything on here that indicates that Dr. Tudor would wait one year prior to undergoing sex reassignment surgery?

A. No.

Q. Where did you learn that, if you did, that Dr. Tudor would wait one year prior to undergoing sex reassignment surgery?

MS. COFFEY: Object to form.

A. I didn't learn she would do anything.

Q. (By Ms. Weiss) Fair enough. Where did you learn that a person -- a transgender person would wait one year prior to undergoing sex reassignment surgery?

MS. COFFEY: Object to form.

Q. (By Ms. Weiss) Let me put it this way: Did you learn anywhere that a transgender person would wait one year before undergoing sex reassignment surgery?

A. Yes.

Q. And where did you learn that?

A. Charlie Babb.

Q. To your knowledge, does Mr. Babb have specialized knowledge about a transgender person's

Exhibit 2

medical treatment?

A. No.

Q. Okay. Did you do anything to find out from more expert people regarding transgender medical treatment?

MS. COFFEY: Object to form.

Q. (By Ms. Weiss) Did you take any other steps to learn about transgender medical treatments?

A. No.

Q. Okay. Which restrooms do non-transgender females on Southeastern's campus use?

MS. COFFEY: Object to form.

Q. (By Ms. Weiss) Sorry. I think I might have said that backwards. Which restrooms do non-transgender females use on the Southeastern campus?

A. Typically, they use female restrooms, family, handicapped, uni-sex.

Q. Are they required to use the uni-sex bathroom?

A. No.

Q. Are they required to use the family bathroom?

A. No.

Q. Are they required to -- what was the other one? Sorry. Uni-sex, family. Strike that. Is there a gender-specific dress code on Southeastern's campus?

A. No.

Exhibit 2

Expert Report of George R. Brown, MD, DFAPA

U.S. et al. v. Southeastern Okla. St. Univ. et al., 5:15-cv-00324-C (W.D. Okla.)

I. Qualifications and Experience

I am a Professor of Psychiatry and Associate Chairman of the Department of Psychiatry at East Tennessee State University in Johnson City, Tennessee. I am board-certified in adult psychiatry. I was named a Fellow of the American Psychiatric Association in 1998 and a Distinguished Fellow in 2003.

I have specialized training and expertise in the diagnosis and treatment of Gender Identity Disorder and Gender Dysphoria ("GID/GD"). I have authored or coauthored 38 papers in peer-reviewed journals and 19 book chapters on topics related to GID/GD, including the chapter on GID/GD in Treatments of Psychiatric Disorders, (3rd Ed. 2001), the definitive text on the diagnosis and treatment of psychiatric disorders published by the American Psychiatric Association. I have been a practicing psychiatrist since 1987. Over the last 33 years, I have evaluated, treated, and/or conducted research with between 600 and 1000 individuals with gender disorders in person, and over 5100 patients with gender dysphoria during the course of research-related chart reviews.

Since 1987, I have been extensively involved with the World Professional Association of Transgender Health ("WPATH"), the only international association of medical, surgical, and mental health professionals specializing in the evaluation and treatment of, transsexual, transgender, and gender non-conforming people (WPATH is the same organization which was previously known as the Harry Benjamin International Gender Dysphoria Association until 2006). I served on the Board of Directors of WPATH from 1993-1997 and from 2001 – 2007 and from 2010-2014. I also served on the Executive Committee of this organization as Secretary-Treasurer from 2007-2009. In addition, I was a coauthor in the development and publication of the World Professional Association of Transgender Health Care's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 (published in 2011 and currently in use), and in the previous 2 versions (versions 5 and 6). I served as a member of WPATH's Standards of Care Revision Committee from 1990-1998 and have been Co-Chairman or a member of that Committee from 2001 to present. These standards for the medical treatment of GID/GD represent the consensus of specialists in the field, and have been recognized as the definitive standards by a number of jurisdictions in the USA and Canada. My current responsibilities involve conducting the largest studies ever developed concerning the health of, and health disparities in, transgender/gender dysphoric people, as well as providing national training programs on transgender health care on a national basis in the Veterans Health Administration

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and for the Department of Defense. More detailed information about my background and experience can be found in my curriculum vitae, which is attached as Exhibit 1.[1]

II. Opinions

I have been asked to render expert opinions in the following areas:

(1) The factors that medical professionals consider when determining a person's sex.

(2) The traits of "gender" and "gender identity," how they relate to a person's sex, and how they relate to "sexual identity."

(3) The traits of being "transgender" and "transsexual" and how they relate to a person's sex.

(4) The condition of "gender dysphoria" (previously called gender identity disorder).

(5) Treatment of gender dysphoria and gender identity disorder.

In forming my opinions, I have relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields (a nonexhaustive list of those references are included at the end of this document), and my 33 years of clinical experience in evaluating, treating, and conducting research with patients with sexual and gender identity issues and gender identity/gender dysphoria disorders. My opinions are set forth below. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

A. Summary of Opinions/Conclusions

"Sex" is complex and requires more than a cursory glance at a newborn's genitalia. Sex involves biological constructs that may or may not be readily observed, and includes the important component of gender. "Gender" involves both gender identity and gender role/expression. Gender identity is an internal, subjective sense of oneself as masculine, feminine, or occasionally some other sense of gender that does not fit readily into the "binary" construct of male/masculine and female/feminine that predominates in our Western culture. Gender role, or expression, is the objective presentation that each of us has as we dress, behave, and interact in society in ways that are understood by others as masculine, feminine, or occasionally some other gender role/expression that does not seem to fit into the binary construct of male/masculine or female/feminine. Everyone has a gender identity and role, and in the vast majority of people, there is consonance between the sex of assignment at birth

[1] Please see Exhibit 2 for information about my compensation for preparing reports and testifying in this case.

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("birth sex") and both gender identity and role. Rarely, there is significant incongruity between "birth sex" and one's gender identity, which can result in a set of clinically significant symptoms described in psychiatric manuals as "gender dysphoria" (GD).

Treatment of GD is guided by the WPATH standards of care, and many individuals with this diagnosis can be fully cured of all symptoms with appropriate treatment. Treatment typically consists of psychological evaluation and therapy, hormonal therapy, living in the felt gender role, and, for some, irreversible surgeries to bring the body into alignment with the subjective experience of gender identity. Part of this transition necessitates the legal assumption of an identity that is consistent with gender identity, e.g. driver's license, amended/changed birth certificate, passport.

B. Determining a person's sex

A person's "sex" is not exclusively or solely defined by one's anatomy or ability to procreate as was often believed in the past (Ovesey and Person, 1973). "Biological sex" is a broad and complex concept that consists of a number of variables, including gender and gender identity, genital anatomy (internal and externally visible), secondary sexual characteristics, brain anatomy, sexual orientation, hormonal levels in the brain and body, and chromosomal complement. Most commonly, the factors that constitute biological sex align and there is little variation. For example, for the vast majority of men, there is a total matching of chromosomes (XY), sexual organ appearance as male (penis and testicles), male hormone levels (predominantly testosterone), and the overall psychological sense of being a man. The American Psychological Association defines "[s]ex as a person's biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female)." "Birth sex" is another term frequently used in medical professionals' discussions of sex, and refers to the sex of assignment at birth as recorded on a birth certificate. "Birth sex" (the sex of assignment at, or near, the time of birth) can be recorded as only "male" or "female" and as such, is an administrative binary terminology that does not take into account the complexity of human experience.

The variables identified above and their role in determining a person's sex are discussed in more detail below.

1. Gender and gender identity

Gender is a component of sex, and like sex, has both a subjective and an objective component. The subjective sense of oneself as masculine, feminine, both, neither or some other gender is commonly referred to as gender identity, is a critical component in determining a person's sex, and is inextricably linked, although partially distinct, from sexual orientation. Gender role is the objective, social expression of gender identity and is usually aligned with gender identity. Most people give no thought to their gender

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identity and whether or not it matches their physical anatomy because no conflict exists. For example, most men get up in the morning, put on clothes that identify them as men in our society, and experience no conflicts or incongruity between their sense of being a man and how they look anatomically and how they present themselves in society as men. However, in rare individuals (recent estimates are 4.6/100,000 births; Arcelus, 2015), gender identity and gender role may not align, and gender identity may not align with the other components of sex. For example, transsexual persons generally experience a lack of alignment between their subjective sense of themselves (gender) and their genital/physical anatomy. Note that "sex" is an integral part of the term "transsexual" (discussed below) which indicates the linkage between gender and sex.

A person's "gender identity" is a component of one's biological sex and refers to "one's sense of oneself as male, female, or transgender" (American Psychological Association, 2006). The American Psychiatric Association defines gender identity as a "category of social identity and refers to an individual's identification as male, female, or occasionally, some category other than male or female." (APA, DSM-5, 2013, pg 451). When one's gender identity and other biological characteristics are not congruent, the individual may experience gender dysphoria (defined below). While "birth sex" (sex of assignment at birth) is usually congruent with a child's gender identity (as experienced and expressed later in childhood), children are sometimes born with anatomical, hormonal, and/or chromosomal variations that do not align with the "birth sex" (genital anatomy) that was recorded by a physician at or near the time of birth. Such children may then develop gender identities and roles that do not align with their "birth sex."

All individuals, not just transgender individuals (who are discussed in section II.C below), have a gender identity. Studies have shown that gender role, as an expression of gender identity, is usually established early in life, by the age of 2-3 years old, and that gender role (behaving as a typical boy or girl in our culture) usually displays very little malleability over time for the vast majority of people (Stoller, 1968**)**, especially after the onset of puberty. Children as young as one year old may display gender-specific behaviors readily recognizable as associated with the "other" sex (Zucker and Bradley, 1995, Chapter 1, page 11).

Gender identity is distinguishable from and exists separately from sexual orientation, which refers to whom a person is sexually attracted. Just as with other individuals, transgender people can have sexual identities/orientations as heterosexual, homosexual, bisexual or asexual.

2. Genital anatomy (internal and externally visible)

A critical component in determining a person's sex is the genital anatomy, which includes both internal (not observable) and external (observable) components. It is the

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appearance of the observable external genitalia that determines the classification of "birth sex," the sex of assignment at birth, and whether "Male" or "Female" is registered on a birth certificate.

3. Primary and Secondary sexual characteristics

Primary sexual characteristics are those features that are not subject to the hormonal changes associated with puberty. These typically include: testes, prostate, seminal vesicles, penis, in "birth sex" males, and ovaries, vagina, uterus, fallopian tubes, clitoris, labia in "birth sex" females. Secondary sexual characteristics are those physical features that develop under the influence of rising levels of sex steroid hormones beginning at puberty. Examples include breasts in women, "Adam's Apple" (enlargement of the front part of the laryngeal cartilage) in men, facial hair in men, widening of the pelvis in women, deepening of the voice in men, and hip-to-waist measurement ratios that are lower in adult females, on average, compared to adult males. These physical changes are dependent on production of adequate amounts of estrogens in females and testosterone in males.

4. Brain anatomy

Brain anatomy is another determinant of a person's sex. Many areas of the brain are different between males and females ("sexually dimorphic" areas of the brain), due to genetics and the amounts of sex steroid hormones present in the developing fetal brain (from any source, including from the woman carrying the fetus).

It is well known that the brains of "birth sex" men and women differ in size in many regions of the brain. These include specific parts of the brain that are visible on MRI studies, including the hippocampus, caudate nucleus, and anterior cingulate gyrus, to name a few, that are larger in "birth sex" women and the amygdala and gray matter volumes that are larger in "birth sex" men. Most studies of gender-typical male and female brains also indicate that the right hemisphere is larger in men than in women.

5. Sexual orientation

"Sexual orientation "refers to the sex of those to whom one is sexually and/or romantically attracted. The term "sexual identity" is often used interchangeably with sexual orientation. Categories of sexual orientation typically have included attraction to members of one's own "birth sex" (gay men or lesbians), attraction to members of the other "birth sex" (heterosexuals), and attraction to members of both sexes (bisexuals). Rarely, some individuals report that they have no attraction to either sex ("asexual"). While these categories continue to be widely used, research has suggested that sexual orientation does not always appear in such definable categories and instead occurs on a continuum. In addition, some research indicates that sexual orientation is fluid for

some people; this may be especially true for women (Nichols, 2004; Peplau and Garnets, 2000).

Although usually aligned, sexual expression/role may or may not be consistent with the subjective sexual identity. For example, a person who has male genitals, a male-differentiated brain, male secondary sexual characteristics (e.g. facial hair, Adam's apple, strong upper body strength), XY chromosomal complement, male levels of brain and body testosterone, and sexual attraction to women (i.e., a heterosexual sexual orientation) as well as a subjective sexual identity as a heterosexual male may nonetheless engage in occasional same-sex sexual behaviors, indicating that sexual identity/orientation and sexual role/behavior may not always align.

6. Hormonal levels in the brain and body

The relative levels of estrogen and testosterone (and their metabolites, or what is left after they are processed by the body) present in the brain and body are also factors that determine a person's sex. Estrogen and testosterone are referred to as "sex steroid hormones" and testosterone and its byproducts are referred to as "androgens." Both the brain and the body have receptors for estrogen and testosterone, which means that the brain and various organs in the body are changed by the presence, or absence, of these two major hormone classes. For example, it is known that both testosterone and estrogen are present in all people, but the relative amount of estrogen compared to testosterone is typically far, far higher in female bodies than in male bodies, whereas the amount of testosterone is typically far greater in male bodies than in female bodies. Variabilities in the amount of these sex hormones, both before and after birth, can have major consequences on the primary and secondary sexual characteristics, the likelihood of homosexual or heterosexual orientation, and the gender role behavior of people with these variances. For example, defects in prenatal sex hormone production can result in ambiguously appearing genitalia at birth, or misclassification of "birth sex" as female when the baby meets the criteria for male sex otherwise (MacGillivray and Mazur 2005). "Birth sex" females with much higher levels of androgens early in life (e.g., congenital adrenal hyperplasia, a genetic absence of an important sex steroid enzyme) may appear to have male genitalia at birth even though they have typically female chromosomes (46XX; see below). Gender identity in these girls is typically female, while gender role behavior may be masculine ("tomboys") and the likelihood of homosexual identity and orientation is much higher (Zurenda and Sandberg, 2003). There are many such conditions, present in both "birth sex" males and females, and collectively these conditions are known as "intersex," disorders of sex development, or "atypical sexual development." (Mazur, et al, 2007).

7. Chromosomal complement

Chromosomes are an important determinant of sex. Typically, most people have 46 total chromosomes, two of which are "sex chromosomes" known as X and Y. The usual situation is for "birth sex" females to have a 46XX pattern, and for "birth sex" males to have a 46XY pattern. If the genes associated with the chromosomes are also typical, there is production of sex steroid hormones in various amounts and at various times during typical physical development such that 46XX is associated with female sex, female genitals, female gender identity and role (see below), and in a similar way, 46XY is associated with male sex, male genitals, male gender identity and role. A single gene on the Y chromosome is responsible for the differentiation of a human embryo into a "birth sex" male fetus with testicular development at approximately 6 to 7 weeks into a pregnancy (Mazur, et al, 2007).

In a fetus with 46XX chromosomes, no testosterone/androgens are secreted, and therefore female genitalia develop.

Uncommonly (but not rarely), there are genetic abnormalities in the fertilized egg that lead to chromosome patterns that are different from either 46XX or 46XY. Examples are numerous and can found in Mazur, et al, 2007. Classic examples include Turners' Syndrome, estimated at 1:2500 live "birth sex" females (46XO, where one sex chromosome is missing), Klinefelter's Syndrome, where an extra X chromosome is present (for example, 47XXY, 48XXYY). This nonheritable genetic abnormality is present in 1:600 live "birth sex" males (Nielsen and Wohlert, 1991).

Some, but not all, disorders of the sex chromosomes are associated with atypical sexual organ appearance, higher rates of homosexuality, bisexuality, or asexuality (that is, little to no sexual attraction to anyone or interest in having sexual relations). Some, but not all, may have atypical gender identity and/or gender role development as well. The key point is that the presence of a typical 46XX or 46XY chromosome pattern is relevant for determining a person's sex but not sufficient, in and of itself, to determine a person's sex.

C. What it means to be transgender or transsexual

The term "transgender" is a relatively recent term used as an umbrella concept for anyone who experiences any significant degree of "mismatch" between subjective gender identity and objective physical/anatomic sex. The term "transgender" is also used to describe people who have transitioned to living as a gender different from what they were assigned at birth. Many people who self-identify as transgender may have only transient problems which may or may not reach a threshold for a psychiatric diagnosis as defined below. "Transsexual" is frequently used to describe people whose gender identity is substantially inconsistent with the sex they were assigned at birth and

such individuals usually seek social transition and some type of medical, psychological, and/or surgical intervention(s) to align their physical anatomy with their subjective gender identity. Therefore, many researchers in this field of study consider the smaller group of transsexual people to be a subset of the much larger group of transgender persons. In any event, the population of transgender people is not known, as there are no large population-based studies. Since many people who self-identify as transgender do not come to clinical attention and gender identity questions are generally not asked on census forms or medical documents, it is not currently possible to know the size of this population. Estimates for transsexual people, who are more likely to come to clinical attention, vary widely, but are listed as from 0.005% to 0.014% for "birth sex" males and from 0.002% to 0.003% of "birth sex" females (APA, DSM-5, 2013, pg 454).

Although the precise etiology of transsexualism is unknown (Ettner, 2007; Lev, 2004), most experts in the study of transgender phenomena agree that there is likely a biological basis for transsexualism and perhaps other transgender phenomena. Even those who espouse the idea that postnatal factors, such as familial interactions, play an important role in gender identity development suspect that biological factors play a role in "inducing a vulnerability that then allows the psychosocial factors within the family to exert their effect" (Bradley, 1985, p. 175).

Much of the evidence in support of a biological basis for gender identity (typical or atypical) is based on comparison studies of the brains of transsexual persons using imaging techniques with live subjects or measurements taken post-mortem (after death). Such techniques were not possible a short time ago, but nonetheless, the concept of a "critical period effect" during fetal brain development was espoused decades ago as an explanation for why some (few) individuals experience gender nonconformity (Kimura 1992). Although it is not possible to directly study the developing human brain before birth, it was proposed that the hormones present in the bloodstream surrounding the developing brain at certain, undetermined critical periods in brain sexual differentiation was altered to the extent that the "brain sex" did not match the otherwise "normal" anatomic/genital sex at birth. This theory more recently received support in a study of fetal testosterone exposure, which showed that amniotic fluid levels of testosterone for "birth sex" male and female fetuses correlated positively with male-typical play patterns in both "birth sex" male and female children (Auyeung, et al, 2009).

Zhou and others reported in 1995 that areas of the brain known to differ in size between men and women generally could be studied in transsexual persons. At least one of these sexually dimorphic brain regions in male-to-female transsexual subjects was consistent with the size seen in "birth sex" females, and not males.

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Additional support for a biological basis for transsexualism was reported by Luders and colleagues, who analyzed MRI data of 24 male-to-female (MtF) transsexuals not yet treated with cross-sex hormones in order to determine whether gray matter volumes in the brains of MtF transsexuals more closely resemble people who share their “birth sex” (30 control men), or people who share their gender identity (30 control women). Results revealed that MtF transsexuals showed a significantly larger volume of regional gray matter in the right putamen compared to the control group of non-transsexual,“birth sex” men. These researchers concluded that their findings provided new evidence that transsexualism is associated with a distinct cerebral pattern, which supports the assumption that brain anatomy plays a role in gender identity.

Savic and Stefan (2011) studied the brains of male-to-female transsexuals compared to “birth sex” controls of the same sexual orientation. The brains of the MtF subjects differed from controls in several regions (e.g., smaller volumes in the putamen and thalamus in MtF). They concluded: “Gender dysphoria is suggested to be a consequence of sex atypical cerebral differentiation.”

Additional studies in support of the hypothesis that gender dysphoria (defined below) is caused by sex atypical differentiation of parts of the brain before birth due to genetic and/or an early organizational effect of testosterone levels during fetal brain development include: Giedd J, Castellanos F, et al, 1997; Green R and Keverne E, 2000; van Goozen S, Slabbekoorn D, et al, 2002; and Swaab D, 2007.

Finally, several other studies have also found distinctive brain patterns in transsexual subjects that differ from what would be expected to be seen in non-transsexual subjects of the same “birth sex” in post-mortem studies: Kruijver F, Zhou J, et al, 2000; Berglund H, Lindstrom P, et al, 2008.

There is a spectrum of severity in the disconnect between subjective gender identity and “birth sex”, with gender dysphoric transsexualism (see D. below) being on the far end of this spectrum. The evidence for transsexualism arising from strictly, or mostly, postnatal influences (such as family interactions, social factors, maternal/paternal rearing styles) is not compelling; nor is the theory that transsexualism is “a lifestyle choice.” Importantly, “birth sex” males who consider themselves to be females (“transwomen”or “male-to-female transsexuals”) and have a female gender identity and female gender role are considered to be women, and not men, whether or not they have had any surgery to alter the appearance or function of their genitalia. Likewise, “birth sex” females who self-identify as male (“transmen”, “female-to-male transsexuals”) and have a male gender identity and gender role are considered to be men and not women irrespective of whether they have had any surgical interventions to change their bodies.

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D. The condition of gender dysphoria

Gender dysphoria (GD) is both a symptom complex and a psychiatric diagnosis. As a set of symptoms, gender dysphoria is a mixture of mood symptoms (irritability, depression, anxiety) and mental distress or discomfort based on the experience of a mismatch between the sex of the body ("birth sex") and the inner, subjective sense of gender. There are degrees of severity of gender dysphoria symptoms, ranging from mild to severe, and such symptoms may be episodic. It is well known that gender dysphoric persons may live in denial of those symptoms and sometimes make life choices that they feel are likely to "purge" cross-gender feelings, e.g. joining the military or pursuing other hypermasculine pursuits in the case of gender dysphoric "birth sex" males (Brown, 1988; 2015; Brown and McDuffie, 2010). It is therefore not uncommon for adults later in life to first "come out" or acknowledge to others their transgender feelings (Lev, 2004).

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5; APA, 2013) is the current, generally recognized authoritative handbook on the diagnosis of mental disorders relied upon by mental health professionals in the United States, Canada, and other countries. Its content reflects a non-ideological, science-based, and peer-reviewed process by experts in the field who have varying perspectives. Prior to the current iteration of the DSM, persons with clinically significant levels of GD symptoms were diagnosed with Gender Identity Disorder (GID).

That diagnosis has since been replaced by the diagnosis of GD in recognition that the essence of the diagnosis is the treatable symptom complex of gender dysphoria, and not a disorder of identity, which remains fixed irrespective of treatment. Most adult patients who would meet the criteria for the past diagnosis of GID would meet the criteria for the current diagnosis of GD. Both GD and GID are diagnostically coded the same (302.85).

Individuals with GID/GD, experience a persistent and recurrent discordance between their anatomical "birth sex" and psychological gender. "Birth sex" males with GID/GD, for example, feel female in their mind and emotions. Individuals with GD are, in essence, psychologically in the "wrong body" and experience significant emotional distress as a result.

The diagnosis of GD in the DSM-5 (pgs 451-459) involves two major diagnostic criteria for adolescents and adults, synopsized below:

> 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:

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1. A marked incongruence between one's experience/expressed gender and primary and/or 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 experience/expressed gender.

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

5. A strong desire to be treated as the other gender

6. A strong conviction that one has the typical feelings and reactions of the other gender

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas as of functioning.

Diagnoses of gender dysphoria may also be designated by one, or both, of two "specifiers:" gender dysphoria with a disorder of sex development; post-transition gender dysphoria (e.g., an individual who has transitioned, or is in the process of transitioning to the desired /felt gender—with or without legalization of gender change) and has undergone, or is preparing to have, at least one cross-sex medical procedure or treatment regimen (for example, regular cross-sex hormonal treatment or gender reassignment surgeries). Like all psychiatric diagnoses, symptoms must be of significant severity to cause notable distress and/or dysfunction in a person's life. The presence of gender nonconformity alone is insufficient to warrant a psychiatric diagnosis.

There is a general agreement in mainstream psychiatry that GID/GD is a legitimate mental disorder and it is recognized as such in standard medical texts (Saddock and Saddock, 2007; Gabbard, 2007). For example, GD, as defined in various iterations of DSM since 1980, is defined and explained in numerous psychiatric textbooks and resources. The term "transsexualism" is no longer a diagnostic term, having been replaced by GID and GD, but the term is still used in professional circles, scholarly works, and treatment guidelines to refer to persons on the extreme end of a continuum of gender dysphoric symptoms (Coleman, et al, 2012).

The World Health Organization also recognizes the discordance between anatomical sex and gender as a disorder in its publication, The International Classification of Diseases (known as ICD 10). The ICD and DSM codes are generally now compatible with each other. The code for transsexualism in ICD-10 corresponds with the DSM-5

diagnosis of GD. While DSM-5 is the primary diagnostic tool used by mental health professionals in the United States, the ICD is also used in this country, predominantly for research, billing and coding purposes.

In spite of research evidence in support of a biological basis for GID/GD, there are no commercially available or reliable biological or laboratory tests that are used in clinical practice to diagnose GID/GD. This is true for virtually all of the mental disorders in the DSM-5 and its predecessors. In fact, Strategic Objective #1 of the National Institute of Mental Health (NIMH) is to "define the mechanisms of complex behaviors," including molecules and genomic factors (NIMH, 2015). This statement is in recognition that even in 2016, we don't know the definitive root cause for mental disorders listed in DSM-5, and we do not have objective tests of body, brain, or fluids that definitively diagnose any mental disorders.

A diagnosis of GID/GD is made by a mental health professional who has training and experience with this disorder and who conducts an in-depth evaluation of the patient, preferably with access to past medical records and collateral history from others who know the individual. The American Psychiatric Association and WPATH (Coleman, et al, Standards of Care, Version 7, 2012) recognize that such diagnoses can be made by a range of trained and experienced mental health professionals.

E. Treatment of Gender Dysphoria (previously Gender Identity Disorder)

Many people initially do not understand their cross-gender feelings and do not have a language for such feelings until well into adulthood. Many "birth sex" males report an extensive history of cross-gender feelings and cross-dressing followed by a variety of attempts to eradicate such feelings, including by marrying and having children or by excessive involvement in stereotypical male behavior (for example joining the military), a phenomenon known as "flight into masculinity" for transgender women (people who transition from male-to-female; Brown, 1988; McDuffie and Brown, 2010; Brown and Jones, 2015). Attempts to repress and suppress gender identity are ultimately unsuccessful and the cross-gender feelings return, often stronger. It may not be until later in life that a person learns that there is a name for their cross-gender feelings. Individuals with severe and prolonged gender conflict frequently have a frantic preoccupation with trying to change their anatomic sex to match their psychological gender. The severe end of the spectrum of GID/GD (which is often referred to as transsexualism) is characterized by significant symptoms of gender dysphoria, whereas many transgender individuals may not experience the symptoms of gender dysphoria, or only to a mild extent or only transiently.

Early attempts at treatment to change transsexuals' gender identity to that congruent with "birth sex" were demonstrated to be ineffective in most cases, prompting the

American Medical Association as early as 1972 to support medical and surgical interventions as the treatment of choice for transsexualism (AMA, 1972). Others noted that psychotherapy, often with associated cross-sex hormonal treatment, was of benefit for some transsexual people with respect to life adjustment, but not for changing one's gender identity (Lothstein and Levine, 1981; Seikowski, 2007). In fact it has been stated that there are no demonstrable, successful "conversions" of transsexual persons' gender identities through the use of psychotherapy (Monstrey, et al, 2007, pg 89), a form of psychotherapy known today as "reparative therapy" or "conversion therapy." These types of therapy are widely considered to be unethical by professional organizations based on the premise that gender identity and sexual identity/orientation are not "changed" by conversion psychotherapies and that emotional harm has been demonstrated in many who have received such therapies in the past (Daniel, et al, 2015). The federal Substance Abuse and Mental Health Services Administration recently issued a report showing that conversion therapy is not an appropriate therapeutic approach based on the evidence. The report also included similar consensus statements developed by an expert panel held by the American Psychological Association in July 2015. The professional organization that was arguably the most involved with attempting to convert both homosexual and transgender persons' identities decades ago has also strongly come out against the use of psychotherapy to attempt to change either sexual or gender identity:

> "Psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes." (American Psychoanalytic Association, 2012).

WPATH has developed Standards of Care ("SOC") for the evaluation and medical treatment of persons with GID/GD. WPATH has over 1000 members worldwide, approximately 70% of whom are in the United States. These members are physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of GID/GD. The "SOC" were first developed in 1979. Currently in the seventh version, the SOC are considered to be authoritative for the evaluation and treatment of gender dysphoria (Coleman, et al, 2012). There are no other comprehensive, widely accepted, medical standards of care for the treatment of GID/GD. As with all medical standards, the SOC are guidelines that can be modified based on the individualized patient circumstances and the health care professional's clinical judgment.

The medical treatment of a person diagnosed with GID/GD is based upon an individualized plan involving one or more of three major components: (1) hormonal

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reassignment to the felt/experienced gender identity; (2) 12 continuous months of living in a gender role that is congruent with the patient's identity (previously known as the "real-life experience") and (3) surgery to change the genitalia and, in some cases, secondary sexual characteristics. These elements have been referred to as triadic therapy. Other treatments may also be sought, including electrolysis, voice therapy, breast augmentation, facial reconstruction, etc. (Coleman, et al, 2012). Although it is not an explicit requirement for surgical treatment, it is recommended that patients who seek such procedures have regular contact with a mental health or other medical professional.

Under the SOC, hormone therapy and surgery have established eligibility and readiness criteria that should be met prior to approval for these somatic treatments. Eligibility criteria generally involve timelines of successful experience with one mode of therapy before the next step should be undertaken. Readiness criteria involve the clinician's assessment of whether the client has demonstrated sufficient consolidation of an evolving gender identity to move on to the next step of transition.

The minimum criteria for genital surgery includes the requirement that one have a persistent, well-documented history of gender dysphoria, the capacity to consent to treatment, be of the age of majority and have any significant medical or health care conditions well-controlled. Lastly, a person seeking genital surgery must generally undergo 12 continuous months of living in a gender role that is congruent with the patient's identity, and obtain two letters of referral from experienced clinicians in a qualifying mental health discipline.

Respectfully submitted,

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Date: 5/27/16

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