

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

UNITED STATES OF AMERICA, )  
)  
Plaintiff, )  
)  
and )  
)  
DR. RACHEL TUDOR, )  
)  
Plaintiff/Intervenor, )  
)  
v. ) Case No. 5:15-CV-00324-C  
)  
SOUTHEASTERN OKLAHOMA )  
STATE UNIVERSITY, )  
)  
and )  
)  
THE REGIONAL UNIVERSITY )  
SYSTEM OF OKLAHOMA, )  
)  
)  
Defendants. )

**DR. RACHEL TUDOR'S OPPOSITION  
TO THE UNITED STATES' MOTION TO  
DISMISS THE UNITED STATES' CLAIMS**

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Dr. Tudor opposes the United States' motion to dismiss its claims (ECF No. 1) with prejudice, (US Motion, ECF No. 164; US Brief in Support, ECF No. 165) for the limited purpose of requesting that the Court place conditions upon the dismissal to ensure that Dr. Tudor is not prejudiced. In the event that the Court deems it infeasible to impose conditions on the dismissal sufficient to protect Tudor from prejudice, Dr. Tudor respectfully requests that the Court deny or delay making a decision on the United States' motion to dismiss until the final resolution of Dr. Tudor's claims.

## **I. Introduction and Background**

Dr. Tudor finds herself in an unusual and unenviable position. After more than two and a half years of co-litigation, the United States has settled its mirror claims and resolved to dismiss them with prejudice, leaving Tudor to continue her fight onward through summary judgment and an impending jury trial. Making matters worse, Defendants and the United States have refused Tudor concessions she urges are necessary to protect her from prejudice.

Prior to the filing of this case, the United States entered into a Common Interest Agreement with Tudor, covering any litigation against Defendants and settlement discussions related to the case. Under shield of the Common Interest Agreement, Tudor and her counsel and the United

States and its counsel divulged sensitive and privileged facts, strategies, and legal theories undergirding both parties' cases in chief.

The United States initiated this Title VII enforcement case on March 30, 2015 (ECF No. 1). Ten days later, Dr. Tudor timely moved to intervene and join an additional claim (ECF No. 7). Tudor filed her Complaint-in-Intervention (ECF No. 24) on May 5, 2015. The United States' Complaint sets forth facts and two claims—sex discrimination and retaliation arising under Title VII—that fully overlap with facts and claims brought by Tudor. (Tudor's Complaint-in-Intervention also sets forth a Title VII hostile work environment claim, which relies upon commonly pled facts, and also pleads additional facts which further buttress her environmental claim.)

Up through August 29, 2017, the United States and Tudor closely co-litigated this case through, among other things, heavy motion practice, discovery involving dozens of depositions and tens of thousands of pages of responsive documents, pre-trial filings, multiple scheduling orders, made initial joint preparations for a jury trial which is currently scheduled for November 7, 2017, and otherwise shared resources, including expert witnesses Drs. Parker and Brown.

On August 30, 2017, with only a few weeks remaining in discovery and just over two months until trial, the United States and Defendants reached a

Compromise Agreement.<sup>1</sup> By letter on that same day, the United States notified Tudor that the Common Interest Agreement “is no longer in effect.” Soon thereafter, the United States released Drs. Parker and Brown—experts timely designated by the United States in August 2016 (ECF No. 107)—from retainers and raised no objection to Tudor privately retaining Drs. Parkers and Brown or her utilizing their previously disclosed expert reports going forward.

On August 31, 2017, the United States and Defendants formally asked Tudor to stipulate to the United States’ dismissal pursuant to Fed. R. Civ. P. 41(a)(1)(A)(ii) without prejudice. Tudor asked both parties to give her time to consider her options.

On September 1, 2017 and September 4, 2017 Dr. Tudor’s counsel formally retained Dr. Parker and Dr. Brown, respectively. Shortly thereafter, Tudor notified the United States and Defendants that she had retained Drs. Parker and Brown and desired to use them as her own experts going forward relying upon the expert reports that the United States had disclosed more than a year prior. In an attempt to avoid inconvenience to Defendants, Dr. Tudor requested that Defendants agree to keep the previously agreed upon

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<sup>1</sup> A copy of the Compromise Agreement was filed *ex parte* and under seal by Tudor as an exhibit to her brief in opposition to Defendants’ motion for protective order. *See* ECF No. 173, Exhibit 1.

<sup>2</sup> Pursuant this Court’s Order (ECF No. 175), deadlines for matters

September 12, 2017 (Brown) and September 18, 2017 (Parker) deposition dates; Defendants refused.

Moving forward, and in good faith, Dr. Tudor reached out to the United States and Defendants to attempt to reach an agreement on language for stipulations tailored to prevent prejudice to Tudor upon the dismissal of the United States from this action. As to a stipulation under Rule 41(a)(1)(A)(ii), Dr. Tudor requested that in any joint motion for stipulation of dismissal the parties agree to language which makes clear there is no preclusive effect as to Tudor's claims and/or facts underlying her claims and further that the dismissal of the United States not trigger any election of remedies as to Tudor. Dr. Tudor also sought additional conditions. As to Defendants, Dr. Tudor requested that Defendants stipulate that Dr. Tudor is permitted to use Drs. Brown and Parker going forward as experts and stick with deposition dates previously selected by Defendants. Dr. Tudor also requested that the United States refrain from making filings or statements touching on the scope of Title VII's protections in her case and the merits of Tudor's case (and overlapping points in the United States' case) until Tudor's case is finally resolved. Both Defendants and the United States refused Tudor's requested concessions.

On the afternoon of September 7, 2017, the United States and Defendants notified Tudor of their intent to move to dismiss the United

States' claims *with prejudice* pursuant to Rule 41(a)(2). In response, Tudor notified both parties of her intent to oppose the dismissal in order to seek conditions on the dismissal from this Court.

Pursuant to this Court's scheduling order (ECF No. 142 as modified by ECF No. 175), discovery closed and dispositive motions and *Daubert* motions for matters between Tudor and Defendants became due on September 22, 2017.<sup>2</sup> On that same day, Defendants filed a motion for summary judgment as to all of Tudor's claims (Defs. SJ Mot., ECF No. 177).

Defendants' motion leans heavily on arguments and legal theories that would be unviable if Tudor was given the concessions she sought from the parties in exchange for her agreement to stipulate to the dismissal of the United States. For example, Defendants raise factual arguments regarding the nature of "biological sex" that are refuted by Dr. Brown's testimony. *See* Defs. SJ Mot. at 20 ("[S]ex' means a person's biological status and [*sic.*] male or female. Intervenor has not plead [*sic.*], nor can she show, that she is biologically female. This fact precludes her from proving that she belongs to a protected class of 'female', which precludes her from satisfying the first element under *McDonnell Douglas*."). *But see Exhibit 1*, Brown Report at 3

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<sup>2</sup> Pursuant this Court's Order (ECF No. 175), deadlines for matters involving the United States save for Defendants' motion for protective order (ECF No. 156) and the United States' motion for dismissal (ECF No. 164), are temporarily stayed.

(opining that “[b]iological sex’ is a broad and complex concept that consists of a number of variables, including gender and gender identity, genital anatomy, sexual orientation, hormonal levels in the brain and body, and chromosomal complement.”); *id.* at 8 (explaining there is “evidence in support of a biological basis for gender identity”). (To date, Defendants have not filed any motion seeking to exclude Dr. Brown.)

Defendants’ summary judgment motion also raises arguments touching on contested pretext issues concerning the nature of tenure and promotion as well as evaluations of Tudor’s and comparators’ portfolios which Tudor needs to rebut by pointing to Parker’s testimony. *See, e.g.*, Defs. SJ Mot. at 22–24 (arguing the Court must give deference to Southeastern’s administrative decision-makers in tenure process that Tudor was unworthy of tenure for non-discriminatory reasons); *id.* at 25–26 (arguing that Tudor was unworthy of tenure and has not made showing of pretext). The value of Parker’s testimony is clear. Indeed, the Court recently decided that Parker qualified as an expert and that his testimony is relevant to “questions of pretext.” Order, ECF No. 163 at 3 (“[Parker] is qualified to explain to the jury the tenure application process, his consideration of Dr. Tudor’s work, and his comparison of that work of other applicants who were offered tenure.”); *id.* at 4 (Dr. Parker’s testimony is relevant to “questions of pretext” that may arise in a motion for summary judgment).

Additionally, Defendants ostensibly argue in their summary judgment motion that the United States' supposed change in position as to Title VII's coverage of sex discrimination claims brought by transgender persons should disrupt this Court's prior ruling of law. *See* Defs. SJ Mot. at 19 (obliquely suggesting that the United States has changed its position as to the scope of Title VII's reach in sex discrimination cases involving transgender persons as evidenced by excerpted text from an *amicus* brief it filed in *Zarda v. Altitude Express*, 15-3775 (2d Cir.))<sup>3</sup>; *id.* at 20 ("Under the authority and reasoning recently offered by the United States of America, 'sex' means a person's biological status and [*sic.*] male or female."). *But see* Order, ECF No. 34 at 4–5<sup>4</sup>.

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<sup>3</sup> Defendants correctly quote from part of the United States' brief in *Zarda*, but mistakenly cite and attach as an exhibit a brief filed by other *amici* in that same case to their summary judgment motion.

<sup>4</sup> Therein, this Court held,

Defendants argue Dr. Tudor fails at the first step because she cannot establish she is a member of a protected class. According to Defendants, in *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215 (10th Cir.2007), the Tenth Circuit held a transsexual individual is not within a protected class. However, the reasoning relied on by the Tenth Circuit in *Etsitty* is inapposite here. The Tenth Circuit's holding was that "transsexuals may not claim protection under Title VII from discrimination based solely on their status as a transsexual." *Id.* at 1222. The Circuit went on to clarify that "like all other employees, such protection extends to transsexual employees only if they are discriminated against because they are male or because they are female." Here, it is clear that

## II. Standard for Imposing Conditions on or Withholding Dismissal Pursuant to Rule 41(a)(2)

Dismissal pursuant to Rule 41(a)(2) is wholly within the discretion of the district court. *Clark v. Tansy*, 13 F.3d 1407, 1411 (10th Cir. 1993). The purpose of the rule is “primarily to prevent voluntary dismissals which unfairly affect the other side, and to permit the imposition of curative conditions.” *Id.* (cleaned up).

Factors that a district court shall consider on a Rule 41(a)(2) motion include: the opposing party’s trial preparation efforts and expenses incurred therein, excessive delay or lack of diligence by the moving party, sufficiency of the explanation for requested dismissal, and the “present stage of the litigation.” *Ohlander v. Larson*, 114 F.3d 1531, 1537 (10th Cir. 1997); *Stewart*

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Defendants' actions as alleged by Dr. Tudor occurred because she was female, yet Defendants regarded her as male. Thus, the actions Dr. Tudor alleges Defendants took against her were based upon their dislike of her presented gender. The Tenth Circuit recognized this distinction in *Etsitty* at n. 2, when it cited to the Sixth Circuit case of *Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir.2004) (“Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior; a label, such as ‘transsexual,’ is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender non-conformity.”). The factual allegations raised by Dr. Tudor bring her claims squarely within the Sixth Circuit's reasoning as adopted by the Tenth Circuit in *Etsitty*. Consequently, the Court finds that the discrimination occurred because of Dr. Tudor's gender, and she falls within a protected class. The first element is adequately pled.

v. *KFOR-TV*, 2006 WL 1702493 at \*2 (W.D.Okla. 2006) (Cauthron, J.) (similar). “The Court should also consider other unique factors, if any, relevant to the instant action [ . . . ], including curative conditions negating legal prejudice, and may take a broad view of all relevant facts considered.” *Stewart*, at \*2 (citing *Brown v. Baeke*, 413 F.3d 1121, 1124 (10th Cir. 2005)).

“Not all factors considered need be resolved in one party’s favor” *Stewart*, at \*2 (citing *Ohlander*, 114 F.3d at 1537). “[T]he important aspect is whether the opposing party will suffer prejudice in the light of the valid interests of the parties.” *Clark*, 13 F.3d at 1411. “In reaching its conclusion, ‘the district court should endeavor to insure substantial justice is accorded to [all] parties’, and therefore the court ‘must consider the equities not only facing the defendant, but also those facing the plaintiff.’” *Cty. of Santa Fe, N.M. v. Pub. Serv. Co. of New Mexico*, 311 F.3d 1031, 1048 (10th Cir. 2002) (quoting *Ohlander*, 114 F.3d at 1537).

**Prejudice.** Courts take an expansive view of what amounts to prejudice in the context of Rule 41(a)(2) dismissals. For example, prejudice may be present where an opposing party loses a substantial right as a result of dismissal. *Durham v. Florida East Coast Ry. Co.*, 385 F.2d 366, 368 (5th Cir. 1967) (explicating basic rule). Similarly, prejudice may exist where other burdens appear to be extreme or unreasonable. *See, e.g., Watson v. Clark*, 716 F.Supp. 1354, 1356 (D.Nev. 1989) (explicating basic rule, but not finding

such conditions exist where party moved for dismissal without prejudice, dismissal filed shortly after answer filed, “extensive discovery” not undertaken, and no inordinate amount of time expended on trial preparation).

Where the moving party seeks to dismiss with prejudice predicate and/or overlapping claims that are maintained by a non-settling intervenor whom opposes the dismissal, the requested dismissal prejudices the intervenor and thus should be denied. *See, e.g., Wilkerson v. Schirmer Eng’g Corp.*, 2009 WL 2766716 at \*4 (D.Colo. 2009) (Trustee’s claims which overlap with those of real party in interest in Title VII case cannot be voluntarily dismissed because dismissal would prejudice real party in interest); *Romoland Sch. Dist. v. Inland Empire Energy Ctr., LLC*, 548 F.3d 738, 750 (9th Cir. 2008) (where moving party’s proposed order seeks to dismiss its own claims with prejudice and apply “law of the case” doctrine to claims which overlap with intervenor’s claims, dismissal cannot be granted because it would effectuate dismissal with prejudice of intervenor’s mirror claims which sows prejudice against intervenor); *ITV Direct, Inc. v. Healthy Solutions, LLC*, 445 F.3d 66, 70–71 (1st Cir. 2006) (opposing “intervenor’s interests should also be considered”; dismissal cannot be granted where it would in effect give priority to plaintiff’s resolution of its own claims over intervenor’s

resolution of its claims; allowing priority of claims amounts to prejudice against intervenor weighing against dismissal).

***Placing conditions on dismissal.*** Courts routinely place conditions on dismissals under Rule 41(a)(2) to ensure fairness to the non-moving parties. *See, e.g., Snyder v. Francis Tuttle Tech. Ctr. Sch. Dist. No. 21*, 2008 WL 2558002 at \*1 (W.D.Okla. 2008) (Cauthron, J.) (conditioning dismissal without prejudice on term that moving plaintiff will pay all or part of costs of present litigation if he refiles his case against some or all of defendants in the future).

***Denying or withholding dismissal.*** In a rare situation—like this one—where a plaintiff moves to dismiss with prejudice but the plaintiff-intervenor opposes claiming prejudice will result, the district court may deny dismissal and leave the moving plaintiff to not prosecute its case until final resolution of the intervenor’s claims. *See, e.g., Cty. of Santa Fe, N.M. v. Pub. Serv. Co. of New Mexico*, 311 F.3d 1031, 1048–50 (10th Cir. 2002) (denying dismissal with prejudice where intervenors would be adversely impacted by plaintiff’s dismissal); *id.* at 1049 (finding no serious prejudice to settling plaintiff if forced to remain in the case until resolution of intervenors’ claims); *id.* at 1050 (finding that if intervenors did not succeed on merits claims “that will end the matter” for both intervenors and plaintiff).

Alternatively, in rare situations—like this one—where dismissal would prejudice remaining parties, a court may exercise its prerogative to manage its own docket and delay making a decision on the dismissal motion until the remaining party's claims, which would be prejudiced by a dismissal, are finally resolved. *Baca v. Berry*, 806 F.3d 1262 (10th Cir. 2015) (*quotations omitted*) (though *Ohlander* places some constraints on court's ability to deny Rule 41(a)(2) motion, district court retains broad discretion to stay proceedings as an incident to its power to control its own docket and thus may stay or delay making decision on dismissal which would otherwise result in prejudice).

### III. Arguments

#### A. Condition dismissal of the United States' claims.

##### 1. No Preclusive Effect on Facts or Claims

Dr. Tudor will be prejudiced if the United States' claims are dismissed with prejudice because such dismissal could be construed as a judgment or ruling which precludes Tudor's continued litigation of her mirror claims as well as commonly pled facts which support Tudor's environmental claim.

Dismissal of claims with prejudice constitutes a judgment on the merits of the dismissed claims. *Crowley v. Jones*, 2007 WL 4788471 at \*3 (W.D.Okla. 2007) (*citing Clark v. Hass Grp., Inc.*, 953 F.2d 1235, 1238 (10th Cir. 1992)) (Rule 41(a)(2) voluntary dismissal of action with prejudice constitutes

judgment on the merits of the claims dismissed). If the United States' claims are dismissed with prejudice, Defendants could claim *res judicata*<sup>5</sup> or its cousin doctrine, law of the case,<sup>6</sup> effectively dispose of Tudor's mirror claims and facts supporting those claims that both Tudor and the United States pled. (This could potentially also deprive Tudor of moving forward on her hostile work environment claim which relies in part on commonly pled facts.)

As explained above, dismissing the United States claims with prejudice would rob Tudor of her ability to continue her own case forward. This would be prejudicial to Tudor on its face, and thus the Court should deny the United States' motion. *See, e.g., Wilkerson*, at \*4; *Romoland Sch. Dist.*, 548 F.3d at 750; *ITV Direct, Inc.*, 445 F.3d at 70–71. However, the Court could condition dismissal by dismissing the United States' claims without prejudice, and include a statement in its order clarifying that the dismissal has no preclusive effect on Tudor's mirror claims and commonly pled facts.

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<sup>5</sup> *See MACTEC, Inc. v. Gorelick*, 427 F.3d 821, 831 (10th Cir. 2005) (The “doctrine of *res judicata*, or claim preclusion, . . . prevent[s] a party from relitigating a legal claim that was or could have been the subject of a previously issued final judgment.”); *id.* at 831 (“claim preclusion applies when three elements exist: (1) a final judgment on the merits in an earlier action; (2) identity of the parties in the two suits; and (3) identity of the cause of action in both suits”)

<sup>6</sup> *See Concrete Works of Colo., Inc. v. City and Cty. of Denver*, 321 F.3d 950, 992 (10th Cir. 2003) (cleaned up) (Under law of the case doctrine, “a legal decision made at one stage of litigation, unchallenged in a subsequent appeal when the opportunity to do so existed, becomes the law of the case for future stages of the same litigation, and the parties are deemed to have waived the right to challenge that decision at a later time.”).

## 2. No Election of Remedies

Dr. Tudor will be prejudiced if the Court does not condition and clarify in its order that the dismissal of the United States' claims does not trigger election of remedies as to Tudor on her mirror claims.

In this case, Tudor and the United States have brought two mirror claims and sought similar injunctive and compensatory relief. Where the federal government brings an enforcement action that the charging party joins as an intervenor, election of remedies is triggered where one of the parties fully resolves overlapping claims and another party proceeds in the litigation, seeking relief on those same claims. *See EEOC v. Joslin Dry Goods Co.*, 240 Fed.Appx. 255, 258 (10th Cir. 2007) (observing [but not ultimately deciding issue because charging party's attempted intervention was denied] that where charging party settles claims but EEOC proceeds litigating same claims, if EEOC were to prevail on same claims there is a potential for "double recovery"). *Cf. Boulware v. Baldwin*, 545 Fed.Appx. 725, 728 (10th Cir. 2013) (where overlapping sets of claims seek to remedy the same wrong, "obtaining relief would right the wrong twice").

However, since Tudor was not a party to the Compromise Agreement, the United States' settlement with Defendants should not be used as a means to shield Defendants from *any* remedies sought by Tudor if she prevails on the merits of her mirror claims. Plainly, it would prejudice Tudor to deprive

her of the ability to seek greater relief than that secured by the United States under the Compromise Agreement. *See Wheeler v. Am. Home Prod. Corp. (Boyle-Midway Div.)*, 582 F.2d 891, 896 (5th Cir. 1997) (a stipulation settlement between some parties but not intervenors should not be used to foreclose intervenors' trial on remedies they timely sought prior to stipulation settlement). Under these circumstances, it is appropriate for the Court to condition dismissal with a holding that the dismissal does not trigger an election of remedies as to Tudor.

### **3. Tudor May Use Drs. Parker and Brown as Experts**

Dr. Tudor will be prejudiced if the Court does not condition dismissal of the United States' claims on allowing Tudor's continued use of experts Drs. Parker and Brown.

Up until the execution of the Compromise Agreement, Tudor and the United States shared resources, including experts Drs. Parker and Brown. Though Drs. Parker and Brown were first retained and designated by the United States, at all times Tudor intended to rely upon and use Parker and Brown to buttress her mirror claims. Up to this point, it has been commonly understood that both experts would be utilized by the United States and/or Tudor.<sup>7</sup>

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<sup>7</sup> Indeed, in filings and Orders, the parties and the Court have referenced the designated experts as being collectively the Plaintiffs' experts.

Upon learning that the United States settled its claims, Tudor reached out to and retained both Drs. Parker and Brown and quickly notified all parties. As described *supra* Part I, in their summary judgment motion Defendants are now directly attacking issues and facts Drs. Parker and Brown address in their expert reports and/or are prepared to testify to during the jury trial.

Stripping Tudor of her ability to use Drs. Parker and Brown, so close in time to trial—out of time to designate new experts and with no practical ability to vet new experts in time for depositions let alone trial—would unfairly prejudice Tudor. *Cf. Mannering v. Exxonmobil Oil Corp.*, 2005 WL 2210233 at \*2 (W.D.Okla. 2005) (conditioning dismissal of federal action on condition that parties use “the discovery and expert witnesses in this case” in parallel state action). Tudor would also be prejudiced if she is deprived of the ability to use Drs. Parker and Brown’s testimony specifically to rebut Defendants’ arguments raised in their summary judgment motion which aim to attack Tudor’s pretext case and the nature of sex.

Conversely, Defendants do not stand to be harmed if Drs. Parker and Brown are permitted to continue to serve as experts in this case. Defendants

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*See, e.g.*, Defs. First Mot. *in Limine*, ECF No. 98 at 1 (“Plaintiffs offer the testimony of Dr. Robert Dale Parker as a purported expert”); Order, ECF No. 163 at 1 (“[i]n preparation for trial, Plaintiffs have retained Dr. Robert Dale Parker”).

have known the identities of Drs. Parker and Brown and had access to their expert reports since June 6, 2016. *See Exhibit 2* (cover letter disclosing names of experts and disseminating reports as attachments thereto). Moreover, Defendants are well aware of the scope of these experts' expected testimony—and, in the case of Dr. Parker, there is already a Court order (ECF Doc. 163) explicating the permissibility of Parker's testimony and placing limits upon it with the jury.

Taken as a whole, under these circumstances, it is appropriate to condition the dismissal of the United States' claims on Tudor being permitted to continue to use Drs. Parker and Brown as experts.

#### **4. Limit the United States' Filings in and Statements Regarding this Case**

Dr. Tudor will be prejudiced if the Court dismisses the United States' claims without the condition that, *a fortiori*, the United States cannot make filings in or make public statements regarding Tudor's case (or its own overlapping merits case) which cut against the legal theories and factual averments made by Tudor herein.<sup>8</sup> At bottom, placing such conditions on

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<sup>8</sup> Dr. Tudor wishes to clarify that she requests this condition so as to protect herself, her case, and the integrity of this process and these proceedings from future conduct taken on the behalf of the United States. Dr. Tudor does not contend that the U.S. Department of Justice attorneys who have appeared in this matter thus far harbor personal ill-will against Tudor or themselves would capitulate in such actions. However, Tudor is deeply

dismissal of the United States' claims protects Tudor from prejudice and preserves both the integrity of this process and these proceedings.

Dr. Tudor's private case ultimately endeavors to reinstate Tudor at Southeastern Oklahoma State University and otherwise compensate her for the hostilities, sex discrimination and retaliation she endured between 2007 and 2011. One of the key obstacles to Tudor securing this relief is establishing that Tudor is protected under Title VII. More than two years ago, this Court correctly held that the fact that Tudor is a transgender woman does not exclude her from the ambit of Title VII's protection (Order, ECF Doc. 34 at 4–5). In any normal case, such a ruling would allow a plaintiff in Tudor's shoes to settle or otherwise resolve her case on the merits. Unfortunately, Tudor's case is no ordinary case.

The fact that Tudor's case involves a transgender person makes it of key import to the broader civil rights movement and of key concern to those who desire deprive transgender Americans of Title VII's protection.<sup>9</sup>

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concerned about what direction those attorneys' client will direct them or others to take in the future.

<sup>9</sup> The current political and cultural climate make this obvious. However, to the extent the Court necessitates further evidence, it need look no further than Defendants' foray into *Texas et al. v. United States et al.*, 7:16-cv-00054 (N.D.Tex. filed May 25, 2016) and the United States' and Tudor's appeals of the preliminary injunction issued therein styled as *Texas et al. v. United States et al.*, 16-11534 (5th Cir.) (collectively, "the *Texas* Litigation"). As the Court is aware, the State of Oklahoma (of which Defendants are sub-divisions)—among other plaintiff states and state sub-

Unfortunately, given the recent change in federal administration and increasing public scrutiny of civil rights matters involving transgender Americans, Tudor's case is uniquely vulnerable to attacks by the United States if it is dismissed from this case without conditions imposed on it limiting its further participation and speech.

There are two key reasons why the United States is prone to take actions that are prejudicial to Tudor upon its dismissal.

First, upon information and belief,<sup>10</sup> the United States desires to change its litigation position as to Title VII's coverage of transgender

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divisions—attempted to use the *Texas* Litigation as a vehicle to get a nationwide declaratory judgment redefining Title VII and Title IX to exclude transgender persons from protection and thereby prohibit the United States and its agencies from protecting transgender Americans from sex discrimination in schools and workplaces. The *Texas* Litigation plaintiffs also sought to collaterally attack this Court's earlier decision (Order, ECF No. 34) finding Tudor is protected under Title VII under a sex stereotyping theory. Indeed, for many months, Tudor's case in this Court was stayed while Tudor challenged the Northern District of Texas court's power to enjoin *this case*. (Tudor's efforts ultimately helped get the preliminary injunction dissolved and forced the withdrawal of the *Texas* Litigation.) Suffice to say, Tudor's case is not an ordinary case given who she is and what she alleges herein. Moreover, it is not unfathomable that Tudor might face atypical obstacles to prosecuting her merits case going forward.

<sup>10</sup> This is based upon the expertise and observations of Dr. Tudor's counsel on the new administration's attempts to reorient litigation postures across a wide swath of civil rights matters, including matters involving transgender Americans. Neither Dr. Tudor nor her counsel are privy to privileged internal deliberations by the United States and its counsel concerning litigation strategy outside of discussions directly related to the co-litigation of Dr. Tudor's case which were subject to and remain subject to the now defunct Common Interest Agreement.

persons. But, as a party to Tudor's case, the United States is in an awkward bind. Tudor's case is the United States' first enforcement litigation advancing an interpretation of Title VII which reaches sex stereotype discrimination experienced by transgender persons; this Court previously issued a ruling settling the scope of Title VII's coverage which is law of the case (ECF Doc. 34 at 4–5); and Tudor's case is the only Title VII case involving a transgender charging party filed by the prior administration still in the United States' litigation portfolio. While it is still a party to this case, the United States cannot take positions in other matters that are in conflict with its position in this case. *But* the United States can change its litigation position if it exits this case.

Second, Tudor's case is set for a jury trial in November 2017—falling within the first year of the new administration's changed approach to transgender Americans, including its high-profile efforts to kick transgender soldiers out of the military<sup>11</sup>. The quickly approaching jury trial in Tudor's case makes a change in the United States' nationwide position particularly urgent.

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<sup>11</sup> See Leo Shane III and Tara Copp, *Trump Says Transgender Troops Can't Service in the Military*, Military Times, July 26, 2017, <http://www.militarytimes.com/news/pentagon-congress/2017/07/26/trump-says-transgender-troops-cant-serve-in-the-military/> (“Transgender individuals could be kicked out of the military and banned from enlisting under a policy change announced by President Donald Trump on Twitter Wednesday morning.”).

If this Court does not condition dismissal of the United States on a judicially enforceable prohibition barring it from taking actions that undermine Tudor's case until her claims are resolved, Dr. Tudor fears that the United States will, upon its exit, take steps that will prejudice her.

For example, the United States might interfere in these proceedings in ways which undercut Tudor's legal arguments and/or otherwise sabotage her merits case. This possibility is not remote—the United States has recently taken such actions in other high profile civil rights matters, including *Zarda v. Altitude Express*, 15-3775 (2d Cir.). In *Zarda*, the United States filed an uninvited *amicus* brief opposing the charging party's argument that gay persons can seek refuge from sex discrimination under Title VII,<sup>12</sup> used its brief to lash out at the U.S. Equal Employment Opportunity Commission's contrary legal conclusions,<sup>13</sup> and sought and received precious time at oral arguments before the *en banc* Second Circuit to push forward its legally specious arguments<sup>14</sup>. As evidenced by *Zarda*, the United States enjoys a unique prerogative to file briefs and otherwise participate in virtually any federal case unless otherwise limited by a court.

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<sup>12</sup> *Zarda v. Altitude Express*, 15-3775, ECF No. 417 (2d Cir.) (filed July 26, 2017), reprinted at <http://tinyurl.com/y9r496k4>.

<sup>13</sup> See, e.g., *Id.* at 1 (arguing that the EEOC is “not speaking for the United States”).

<sup>14</sup> The Second Circuit has made its recording of the *Zarda* oral arguments available online. *Zarda*, Oral Arg. Audio, 15-3775 (2d Cir. Sept. 26, 2017) (*en banc*), <http://tinyurl.com/ya744hbq>.

As troubling as the United States' actions in *Zarda* are, the kind of prejudice Tudor risks if the United States' dismissal is not conditioned to limit post-dismissal activities in her case is potentially far more devastating. Up until recently, the United States was an active party in this case, co-litigated it along side Tudor, and became privy to otherwise privileged facts, legal strategies, and other issues unique to Tudor's case under the now defunct Common Interest Agreement. The likelihood of prejudice if the United States' dismissal is not conditioned as requested by Tudor is plain to all. Indeed, Defendants gleefully seized on the possibility of the United States turning against Tudor in their recently filed summary judgment motion. *See* Defs. SJ Mot. at 19 [arguing change of United States' position as evidenced by its *Zarda* brief]; *id.* at 20 [citing United States' *Zarda* brief as authority cutting against Tudor's theory of status protection under Title VII].

If left unrestrained, the United States could land devastating blows to Tudor's case—informed by knowledge and insights gained by virtue of its participation in this case and the Common Interest Agreement. Untoward actions by the United States against Tudor would plainly prejudice her and undermine the integrity of this process and these proceedings. This Court is plainly empowered to condition the United States' dismissal as necessary, informed by the unique circumstances and dynamics at play. *Santa Fe*, 311 F.3d at 1048 (*quoting Ohlander*, 114 F.3d at 1537) (“the district court should

endeavor to insure substantial justice is accorded to [all] parties]’, and therefore the court ‘must consider the equities not only facing the defendant, but also those facing the plaintiff”).

Given these unique circumstances, Tudor respectfully requests that the Court condition dismissal of the United States, prohibiting it from submitting filings in or making public statements regarding Tudor’s case until Tudor’s claims are finally resolved.

**B. Alternatively, deny or stay decision on United States’ dismissal motion.**

In the event that the Court finds it infeasible to place the conditions on the United States’ dismissal, the Court has two alternative options, both of which protect Tudor from prejudices identified above and serve the higher purpose of protecting the integrity of process and proceedings.

The first option is to deny the United States’ dismissal outright, keeping the United States as a plaintiff but not requiring the United States to affirmatively prosecute its case. This option is expressly approved in *Cty. of Santa Fe, N.M. v. Pub. Serv. Co. of New Mexico*, 311 F.3d at 1048–50 (10th Cir. 2002). Much as in *Santa Fe*, dismissing the United States with prejudice would adversely affect Tudor but leaving the United States as a party until Tudor resolves her claims would not prejudice the United States. In this scenario, the United States need not actively prosecute its mirror claims. In

this situation, if Tudor loses her case, “that will end the matter” for the United States—it would be deemed to have lost its claims because Tudor lost her claims, ending things entirely for both Tudor and the United States. 311 F.3d at 1049–50. If Tudor wins her case (or settles), the United States can then move to dismiss its claims, without prejudicing Tudor. *Id.* Much as in *Santa Fe*, the fact that the United States had settled its own claims does not preclude this option. *Id.* at 1048.

The second option is for this Court to delay a decision on the United States’ dismissal until Dr. Tudor’s claims are resolved. This option is expressly approved in *Baca v. Berry*, 806 F.3d 1262 (10th Cir. 2015). *Baca* teaches that though *Ohlander* places some constraints on a district court’s ability to deny Rule 41(a)(2) motions, the court retains broad discretion to stay proceedings and/or delay decision-making on motions as an incident to its power to control its own docket. 806 F.3d at 1269–70. Thus, this Court could simply delay making a decision on the United States’ motion—which would not prejudice the United States and would protect Tudor from prejudice—until Tudor’s claims are resolved.

#### **IV. Conclusion**

For all the foregoing reasons, Dr. Tudor respectfully requests that the Court place conditions on the dismissal of the United States’ claims to ameliorate prejudice to Dr. Tudor. In the alternative, Dr. Tudor requests that

the court deny the United States' motion to dismiss its claims. In the second alternative, Dr. Tudor requests that the Court delay making a decision on the United State's motion until Tudor's claims are finally resolved.

Dated: September 28, 2017

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**CERTIFICATE OF SERVICE**

I hereby certify that on September 28, 2017, I electronically filed a copy of the foregoing with the Clerk of Court by using the CM/ECF system, which will automatically serve all counsel of record.

/s/ Ezra Young  
Ezra Young (NY Bar No. 5283114)

**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

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.<sup>1</sup>

## **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

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<sup>1</sup> Please see Exhibit 2 for information about my compensation for preparing reports and testifying in this case.

(“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

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

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 be found in Mazur, et al, 2007. Classic examples include Turner's 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.

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.

#### **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:

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.

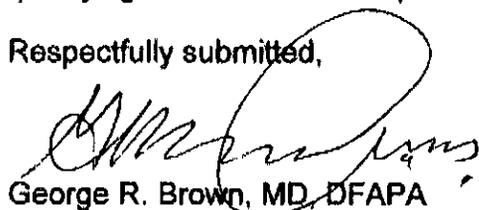
The medical treatment of a person diagnosed with GID/GD is based upon an individualized plan involving one or more of three major components: (1) hormonal

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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Civil Rights Division

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DJ 170-59N-31

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Via E-Mail and U.S. Mail

Dixie Coffey  
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June 6, 2016

Re: *United States & Tudor v. Southeastern Okla. State Univ. & Reg. Univ. Sys. of Okla.*,  
5:15-CV-00324-C (W.D. Okla.)

Counsel:

Pursuant to Federal Rule of Civil Procedure 26(a)(2) and the Court's Scheduling Order (ECF No. 57), the United States designates Dr. George R. Brown and Dr. Robert Dale Parker as expert witnesses in this case. The expert reports of Drs. Brown and Parker are enclosed. Some of the documents identified in Dr. Parker's report are still being Bates numbered and we will provide them to you once they have been Bates numbered.

Thank you for your attention to this matter.

Sincerely,

Delora L. Kennebrew  
Chief  
Employment Litigation Section

By:

Allan K. Townsend  
Shayna Bloom  
Valerie L. Meyer  
Trial Attorneys  
Employment Litigation Section

Enclosure

cc: Jillian Weiss  
Ezra Young  
Brittany Novotny