IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN,

Plaintiff,

v.

ANNE PRECYTHE, et al.,

Defendants.

Case No. 4:16-CV-01357-NCC

REPLY MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S MOTION FOR DECLARATORY RELIEF AND A PERMANENT INJUNCTION

INTRODUCTION

Neither Missouri Department of Corrections ("MDOC") nor Corizon LLC ("Corizon") (collectively, "Defendants") oppose Plaintiff Jessica Hicklin's Motion for Declaratory Relief and a Permanent Injunction (Doc. 163) or offer any arguments against granting the motion and the relief sought therein. *See* Docs. 165, 167, 168. Moreover, the evidence shows that Defendants failed to provide Ms. Hicklin medically necessary gender dysphoria care despite knowing that doing so put her at substantial risk of serious harm.

Even though Ms. Hicklin's psychiatrists recommended hormone therapy, permanent body hair removal, and access to gender-affirming canteen items for her, the evidence shows that MDOC and Corizon[1] repeatedly denied Ms. Hicklin these medically necessary treatments, in violation of her Eighth Amendment rights. Thus, to make clear that these actions violate the Eighth Amendment, and to prevent the irreparable harm that would result if Defendants continue to enforce the freeze-frame policy or withhold Ms. Hicklin's medically necessary gender dysphoria treatment, this Court should grant Ms. Hicklin's Motion for Declaratory Relief and a Permanent Injunction.

STATEMENT OF UNCONTROVERTED FACTS

Ms. Hicklin provides the following replies to Corizon's Answer to her Statement of Uncontroverted Facts.[2] In the interest of brevity, Ms. Hicklin replies only to those paragraphs to which Corizon propounded a response other than an unqualified admission (that is, paragraphs 6, 10, 11, 15, and 16).

[1]The parties have stipulated to the dismissal of the individual Corizon Defendants to streamline the case and facilitate an expeditious resolution of Ms. Hicklin's Motion for Declaratory Relief and a Permanent Injunction. Doc. 169.

[2] MDOC Defendants have taken no position on Ms. Hicklin's Statement of Uncontroverted Facts. Doc. 165.

6. While it is true that treatment of gender dysphoria is individualized, it is also true that, in order to receive the diagnosis of gender dysphoria, a person must experience clinically significant distress or impairment in an important area of functioning, which typically manifests as depression and/or anxiety, along with other mental and physical symptoms. *See* Doc. 64-1 at ¶¶ 12-15; Doc. 168-1 at 1-2 (45:18-46:18). Thus, a person who is not receiving treatment and does not exhibit any of these symptoms by definition does not have gender dysphoria. *See id.* Further, if left untreated, a person with gender dysphoria is likely to suffer additional serious medical problems including suicidality and compulsion to engage in self-castration and self-harm. *See* Ex. O to Second Declaration of Demoya R. Gordon ("2d Gordon Decl."), "Recommended Revisions to the WPATH's Standards of Care Section on Medical Care for Incarcerated Persons with Gender Identity Disorder" (2009), by Corizon's Expert Dr. George Brown ("2009 Brown Article"), at 136; Ex. P to 2d Gordon Decl., "Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder" (2010) by Corizon's Expert, Dr. George Brown ("2010 Brown Article"), at 37-38; Doc. 64-1 at ¶16; Doc. 164-2, Corizon 30(b)(6) Depo. at 95:2-96:4; Doc. 164-3, Atterberry Depo. at 147:19-149:2. This is especially true for persons with severe gender dysphoria like Ms. Hicklin. *See* Ex. Q to 2d Gordon Decl., Excerpted Deposition of Corizon's Expert Dr. George Brown ("Brown Depo.") at 190:24-191:13.

10. The denial of medically necessary gender dysphoria treatment (which, for many people, includes hormone therapy) is likely to lead to significant deterioration and impairment, including depression, suicidal ideation, and surgical self-treatment by auto-castration or autopenectomy. *See* Ex. O to 2d Gordon Decl., 2009 Brown Article, at 136; Ex. P to 2d Gordon Decl., 2010 Brown Article, at 37-38; Ex. Q to 2d Gordon Decl., Brown Depo. at 288:3-5,

288:13; *see also* Doc. 64-1 at ¶¶ 28-33. Again, this is especially true for persons with severe gender dysphoria. *See* Ex. Q to 2d Gordon Decl., Brown Depo. at 190:24-191:13, 288:14-17, 288:19-20.

11. Counseling can provide support for some individuals with gender dysphoria, but it is not a substitute for medical intervention where such intervention is medically necessary. Ex. Q to 2d Gordon Decl., Brown Depo. at 82:5-9, 82:10-15, 82:22-83:3, 83:5-8; Doc. 64-1 at ¶ 35. Merely providing counseling and/or antianxiety or antidepressant medication to a severely gender dysphoric patient is a significant departure from medically accepted practice, and puts the person at serious risk of psychological and physical harm. *See* Doc. 64-1 at ¶ 36; Ex. R to 2d Gordon Decl., Excerpted 2006 Trial Testimony of Corizon's Expert, Dr. George Brown at 203:5-204:16; *see also* 168-1 at 11 (86:1-25).

15. Although Dr. Throop and Dr. Stephens recommended hormone therapy for Ms. Hicklin, the evidence shows that, for almost three years, MDOC and Corizon enforced and implemented the freeze-frame policy by failing to provide Ms. Hicklin hormone therapy based on the fact that she was not receiving such therapy before entering MDOC. *See* Doc. 64-6 at 17, 21, 30-31; Doc. 164-8 at GF 0107, 0127; Doc. 164-9 at Hicklin v. Lombardi 00911-912, 00941-945; Doc. 164-5, Sturm Depo. at 81:13-24, 99:7-21, 132:9-133:6, 145:4-149:1, 154:24-157:3, 160:10-164:25, 172:4-9, 173:15-175:11, 179:2-182:10; Doc. 164-6, MDOC 2d RFA Responses, Nos. 4-6.

16. Like all treatment for gender dysphoria, decisions regarding whether and when a person undertakes changes in gender expression—such as permanent facial/body hair removal or use of gender-affirming personal care items—must be guided by the particular patient's needs. *See* Ex. S to 2d Gordon Decl., Atterberry Depo. at 48:9-23, 49:20-23; Ex. Q to 2d Gordon Decl.,

Brown Depo. at 58:5-14, 58:18-59:5, 168:16-21. The medical records show that gender-incongruent facial and body hair, and lack of access to gender-affirming canteen items, are major contributors to Ms. Hicklin's gender dysphoria and to her recurring thoughts of self-treatment by auto-castration. Doc. 64-4 at 8, 10; Doc. 64-6 at 5, 6, 12, 13, 33-39; Doc. 68-8 at 10; Doc. 164-13 at 3, 5. Hormone therapy does not remove facial or body hair. Ex. T to 2d Gordon Decl., Corizon 30(b)(6) Depo. at 188:24-189:4; Ex. U to 2d Gordon Decl., Excerpted Deposition of Thomas Bredeman ("Bredeman Depo.") at 77:18-78:7.

Dr. Throop and Dr. Stephens are the only MDOC or Corizon employees who have conducted individualized gender dysphoria evaluations on Ms. Hicklin. *See, e.g.*, Ex. S to 2d Gordon Decl., Atterberry Depo. at 132:15-20, 139:3-10; Docs. 114-12, 114-16, 114-18, 114-20, 114-21, 114-22, 114-23, 114-30; Docs. 164-10, 164-11, 164-12. In fact, several of the individual defendants who made decisions regarding Ms. Hicklin's care have never met her. *See, e.g.*, Ex. S to 2d Gordon Decl., Atterberry Depo. at 54:24-55:3; Ex. U to 2d Gordon Decl., Bredeman Depo. at 23:2-3; Ex. V to 2d Gordon Decl., Excerpted Deposition of Glen Babich ("Babich Depo.") at 64:10-18. Neither has Corizon's expert, Dr. George Brown.[3] Ex. Q to 2d Gordon Decl., Brown Depo. at 108:6-10; 156:9-10; 158:17-24; 189:16-25.

Based on her individualized assessment, Dr. Stephens recommended permanent body hair removal and access to gender-affirming canteen items for Ms. Hicklin. Doc. 64-6 at 6, 15, 35. Gender dysphoria expert Dr. Randi Ettner also recommended these items based on *her* individualized assessment of Ms. Hicklin. Doc. 64-1 at ¶ 77. By contrast, Corizon personnel who never individually assessed Ms. Hicklin asserted, baselessly, that these items were not medically necessary and that Ms. Hicklin had to wait until after hormone therapy before receiving access to

[3] MDOC Defendants have disclosed no experts and the deadline for doing so has long passed.

these treatments. Doc. 164-8 at GF 0046, 0151, 0155; Doc. 64-6 at 31-32; Ex. T to 2d Gordon Decl., Corizon 30(b)(6) Depo. at 157:18-160:4, 188:2-14. They did this despite knowing that Ms. Hicklin's facial and body hair and lack of access to feminine underwear and other gender-affirming canteen items cause her great distress, and that the freeze-frame policy barred her from receiving hormone therapy. Doc. 64-4 at 8, 10; Doc. 64-6 at 5, 6, 12, 13, 33-39; Doc. 68-8 at 10; Doc. 164-13 at 3, 5; Ex. S to 2d Gordon Decl., Atterberry Depo. at 143:11-144:14; Doc. 164-2, Corizon 30(b)(6) Depo. at 108:5-23, 143:1-11; Doc. 164-3, Atterberry Depo. at 32:24-33:7; 105:14-106:5, 108:5-23, 113:1-16, 143:1-11; Doc. 164-9 at Hicklin v. Lombardi 00941-945; Ex. T to 2d Gordon Decl., Corizon 30(b)(6) Depo. at 157:18-160:4, 188:2-14; *see also* Ex. Q to 2d Gordon Decl., Brown Depo at 96:22-97:10, 288:22-289:4, 289:12-21.

ARGUMENT

Neither MDOC nor Corizon offered any arguments in opposition to Ms. Hicklin's Motion for Declaratory Relief and a Permanent Injunction. Thus, Ms. Hicklin points the Court to the arguments contained in her opening brief in support of this motion (Doc. 164) and the briefs submitted in support of her previous Motion for Preliminary Injunction (Docs. 64 and 70). Ms. Hicklin also points the Court to the findings of fact and conclusions of law contained in its February 9, 2018 Memorandum and Order. Doc. 145; *Hicklin v. Precynthe*, No. 4:16-CV-01357-NCC, 2018 WL 806764 (E.D. Mo. Feb. 9, 2018).

CONCLUSION

For reasons stated herein and in her opening Memorandum of Law (Doc. 164), Ms. Hicklin respectfully requests that this Court grant her Motion for Declaratory Relief and a Permanent Injunction.

Respectfully submitted this 12th day of April 2018.

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CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that service of the foregoing Reply Memorandum of Law in Support of Plaintiff's Motion for Declaratory Relief and a Permanent Injunction was made on April 12, 2018 via the Court's CM/ECF system to:

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SECOND DECLARATION OF DEMOYA R. GORDON

I, Demoya R. Gordon, hereby declare and state as follows:

1. I am an attorney with Lambda Legal Defense and Education Fund, Inc. and I am one of the lawyers representing Plaintiff Jessica Hicklin in the above-captioned matter.

2. I submit this second declaration in support of Plaintiff's Motion for Declaratory Relief and a Permanent Injunction.

3. Attached hereto as Exhibit O is a true and correct copy of a 2009 article authored by Corizon's Expert, Dr. George Brown, entitled "Recommended Revisions to the World Professional Association for Transgender Health's Standards of Care Section on Medical Care for Incarcerated Persons with Gender Identity Disorder," which was marked as Exhibit 4 to Dr. Brown's deposition.[1]

4. Attached hereto as Exhibit P is a true and correct copy of a 2010 article authored by Corizon's Expert Dr. George Brown entitled "Autocastration and Autopenectomy as Surgical

[1] Since the copies of Exhibits O and P that were marked at Dr. Brown's deposition are somewhat difficult to read, more legible versions are attached along with the copies that were marked at the deposition.

Self-Treatment in Incarcerated Persons with Gender Identity Disorder," which was marked as Exhibit 3 to Dr. Brown's deposition.

5. Attached hereto as Exhibit Q is a true and correct copy of the Excerpted Transcript of the October 23, 2017 Deposition of Corizon's expert, Dr. George Brown.

6. Attached hereto as Exhibit R is a true and correct copy of the Excerpted Transcript of the May 2006 Trial Testimony of Corizon's Expert, Dr. George Brown in *Kosilek v. Massachusetts Department of Correction*.

7. Attached hereto as Exhibit S is a true and correct copy of the Excerpted Transcript of the November 15, 2017 Deposition of Elizabeth Atterberry, Psy. D., Corizon's Mental Health Director.

8. Attached hereto as Exhibit T is a true and correct copy of the Excerpted Transcript of the February 6, 2018 Deposition of Elizabeth Atterberry, Psy. D., in her capacity as Corizon LLC's designated 30(b)(6) Representative.

9. Attached hereto as Exhibit U is a true and correct copy of the Excerpted Transcript of the February 7, 2018 Deposition of Thomas Kevin Bredeman, DO, Corizon's Associate Regional Medical Director.

10. Attached hereto as Exhibit V is a true and correct copy of the Excerpted Transcript of the January 15, 2018 Deposition of Glen Babich, M.D., Corizon's former Associate Regional Medical Director for Missouri.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

Dated: April 12, 2018

Demoya R. Gordon

EXHIBIT

O

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Routledge
Taylor & Francis Group

Recommended Revisions to the World Professional Association for Transgender Health's *Standards of Care* Section on Medical Care for Incarcerated Persons with Gender Identity Disorder

George R. Brown

ABSTRACT. The introduction of comments regarding the care of persons with gender identity disorder (GID) residing in prison settings began in 1998 with Version 5 of the *Standards of Care* (*SOC*), the first major revision of the *SOC* since 1985. Minor revisions to this brief section were made for Version 6 in 2001. Since 2001, there have been many legal and regulatory actions in countries where the *SOC* are widely used as the minimum standards to evaluate and treat persons with GID that have referenced this section in the *SOC*. The original paragraph addressing care for incarcerated persons has proven to be helpful by its existence, but limiting in its brevity and lack of scope. Version 7, likely to be a significant revision compared with the minor changes in Version 6, can be informed by the information that has come to light in the last 6 years, most notably through court actions that have used, or misused, the *SOC*. This invited article reviews the background of this section, rationale for revisions, suggested conceptual changes, and specific content for consideration for inclusion in Version 7 of the *SOC*.

KEYWORDS. Incarceration, autocastration, gender identity disorder, standards of care

Although the majority of persons with gender identity disorder (GID) are marginalized members of most societies, those who are in institutions, including prisons, are doubly so, but no less deserving of compassionate, appropriate health care (Blight, 2000; More, 1996). Indeed, the Eighth Amendment to the U.S. Constitution prohibits cruel and unusual punishment of prisoners in the United States, with case law interpreting this to also mean that "adequate medical care" is guaranteed for those who are incarcerated. The irony in this for Americans is that institutionalized persons have a legal right to health care that is not shared by those in the general population. This reality likely contributes to the difficulty that transgender persons often face with accessing health care and other services in institutional settings. The further refinement and interpretation of the term "adequate" is constantly up for debate and is generally decided by courts, not by clinicians.

Persons diagnosed with GID are a subset of persons who identify as transgender. Although there remains some controversy and evolving debate in consumer and professional circles over whether GID should continue as a psychiatric diagnosis, a "medical" diagnosis, or no diagnosis at all, at the time of this writing GID is a

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The views expressed in this article are those of the author and do not necessarily represent those of the US Government or the Department of Veterans Affairs.

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well-described, formal diagnosis in DSM-IV-TR, and the terminology of the American Psychiatric Association for GID will be used throughout this article. "Transgender" is not a diagnosis, and when used it signifies an umbrella term for any persons who have a gender identity that is variant from the traditional dichotomous masculine and feminine identifications. These individuals may, or may not, have a gender-related diagnosis but may be in need of specialized evaluations and/or medical care.

One of the missions of the WPATH is to advocate for nondiscriminatory, appropriate health care for persons with transgender conditions, independent of HIV status, where they live, their race, their social position, or other demographic variables, unless there is a clinical indication to provide services in a different fashion (Meyer et al., p. 2): "Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol." The majority of persons who meet the SOC for hormonal and surgical intervention would have gender dysphoria and would often meet the current criteria for GID. Therefore, the focus of this article is on those with a diagnosis for whom treatment is well described, although some persons who do not meet criteria for a diagnosis of GID may also benefit from the treatment(s) described in the *SOC*.

Silence on the issues of discrimination against institutionalized persons with GID in the current *SOC* have been misinterpreted by health-care providers, including some current and past members of WPATH, and administrators of institutions or health care plans to mean that there is a tacit approval of some forms of discrimination since these issues are not specifically addressed (e.g., Kosilek v. Mass. Dept. of Corr., 2002). There is wide variation in the application of the current SOC to institutionalized persons with GID. This variation was documented many years ago in a survey of prison transgender health-care policies by Petersen, Stephens, Dickey, and Lewis (1996). I am unaware of more recent surveys of this issue (a survey by the late Gianna Israel, 2002, documented inmate perspectives but did not collect responses from institutions or their administrations), but the included references for prison directives demonstrate that this variability is reified in institutional policies currently on the books. Variability between countries is notable as well. For example, prisoners and other institutionalized persons housed in the United Kingdom have similar access to transgender health care as they would outside of institutions, with care being provided by the National Health Service. Australian prisoners have less access to transgender health care, but with the advocacy of therapists, they are able to access this care, including continuation of, and initiation of, cross-sex hormonal treatments. Persons with GID incarcerated in Brazil have access to transgender health care, including the potential for SRS. One Canadian inmate has been able to access SRS on a self-pay basis.

Strategies used by institutions, some governments, and third-party payers to deny care for institutionalized persons that could otherwise be available for properly diagnosed persons with GID include:

1. Using what the *SOC* do NOT say as a method of denial of care access
2. Placement of the current section on prisoner care (which is too limited in scope) under the hormonal-treatment section has been used to deny care to those in institutions who may need types of care for their GID other than cross-sex hormones
3. Rigid interpretations of the current section to deny care to those who may enter an institution and need treatment started de novo after entry, as opposed to merely continuing existing treatment (sometimes in an ill-conceived "freeze frame" approach that limits transition status to exactly what it was at entry to an institution, even if the expected duration of stay at the institution may be for an extended period of time, up to the remainder of the person's life) (It should be noted that courts have struck down the "freeze frame" approach as not taking into account the individualized health care needs of persons with GID in institutions [see, for example, Kosilek v. Mass Dept. of Corr., 2002].)

4. The limiting of the current *SOC* to "incarcerated persons," as opposed to using more inclusive language, such as "institutionalized persons"
5. Lack of a literature base supporting, or not supporting, the provision of triadic care, in all or in part, for institutionalized persons
6. The belief, not supported by objective fact, that the Real Life Experience (RLE) cannot possibly be negotiated by someone living in an institution, even if that environment is the patient's "real life" circumstance for an extended period of time (This has been used as a way to render a "blanket denial" of any request for surgical intervention by stating that the person cannot ever be referred for surgery because, by this misinterpretation, a RLE cannot possibly occur in an institution.)
7. Basing housing arrangements on the appearance of external genitalia as opposed to taking into consideration the gender role and other clinical circumstances of the resident.

In the current verson of the *Standards of Care* (Version 6), the brief section on the issue is included under Section VII, "Requirements for the Hormonal Treatment of Adults" states the following:

> **Hormone Therapy and Medical Care for Incarcerated Persons**
> Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

RATIONALE FOR REVISIONS

The following points describe the author's rationale for the recommended revisions:

- Current placement of this guidance under the hormones section seems to imply that hormonal treatment is the only issue at stake for institutionalized persons, and that is clearly not the case. Access to the full spectrum of potential treatments, including psychotherapy, must be addressed.
- Lack of comment in this brief section on issues regarding other treatments, including triadic therapy in general, keeps this population vulnerable and unable to access treatments as an unintended consequence of the "silence" on these issues in the current *SOC*.
- Accumulation of case law and use of the *SOC* in various courts since the publication of Version 6 informs us more and enables us to consider modern revisions for this section. I have included some references at the end of this article in support of this statement. For example, at least one major court case at the federal-district-court level in the United States (Kosilek v. Mass. Dept. of Corr., 2002) ruled that:

  1. GID is a serious medical need warranting treatment, even in prison.
  2. The Real Life Experience is possible in a prison setting.
  3. Treatment for persons with GID should be individualized, with no "blanket denials" of care for incarcerated persons properly diagnosed with GID.
  4. Hormones could be started de novo for prisoners if medically appropriate, with determination of medical need to be made by health care providers and not by administrators.
  5. Natal males with GID in a prison setting could have access to the same items as other females in the state's

institutions, e.g. cosmetics, female undergarments, longer nails and hair, and "unisex" prison clothing.

As a result of this 2002 ruling in a U.S. federal district court, an inmate with GID diagnosed by nearly a dozen professionals with expertise in evaluating and treating GID received access to de novo cross-sex hormones, female undergarments, laser electrolysis, cosmetics, and the opportunity to be evaluated for SRS.

These same issues are playing out across the United States and in numerous states at the time of this writing. Legal name changes for natal males to female names are generally not impeded. Provision of hormonal treatment in some institutions is highly variable. Some states allow for only continuation of treatments at the same levels as entry into an institution (e.g., the Colorado Department of Corrections), while others allow for both continuation and for de novo initiation of cross-sex hormonal treatments (e.g., the Wisconsin Department of Corrections, Idaho Department of Corrections, Federal Bureau of Prisons, and California Department of Corrections). The case of *Burt v. Hawk* (1996/1998) is an example of de novo initiation of cross-sex hormonal treatment for a prisoner in federal custody; the case of *Kosilek v. Massachusetts Department of Corrections* (Maloney) is an analogous case for initiation of cross-sex hormone treatment in a state prison. It should be noted that although de novo initiation of cross-sex hormones may be allowed in institutional settings, these directives are not always complied with (Brown, 2007).

Lack of access to transgender health care in institutions has caused, or contributed to, serious negative health outcomes including depression, exacerbation of other mental illnesses, suicidal thinking and behavior, and autocastration and/or autopenectomy (Blacker and Wong, 1963; Brown, 2001, 2003, 2007; Catalano, Morejon, Alberts, & Catalano, 1996; Conacher & Westwood, 1987; Haberman & Michael, 1979; McGuire, Ahmed, & Nazeer, 1998; Nakaya, 1996; Novello & Primavera, 1990; Springer, 1981). Indeed, the early work of Abraham on two of the earliest cases of SRS noted:

> It was not easy for us to decide on the described procedures, but the patients were not to be dismissed, but also were in a mental state that made it probable that self-mutilation, with life-endangering complications, could be possible. (Abraham, 1997; translated from the original 1931 German text)

Abrupt discontinuation of cross-sex hormonal treatments (e.g., in Wisconsin prisons after the passage of Act 105 by the Wisconsin legislature in late 2005, prohibiting hormonal and surgical treatment of inmates in the Wisconsin Department of Corrections) can result in negative health outcomes as well, including the previously mentioned symptoms and involution of acquired secondary sexual characteristics, which in turn exacerbate depression, gender dysphoria, emotional lability (Brown, 2001). While medical care issues are the focus of much of the *SOC*, it cannot be overemphasized that institutionalized (not only incarcerated) persons with GID and other persons with transgender issues face problems related to safe-housing arrangements, potential for sexual and physical assault, and difficulties with access to standard programming like substance-abuse group counseling in a residential setting. The placement of transgender persons in institutions is often problematic, and usually based on anatomy. For example, state and federal prison systems in the United States place inmates with others who have the same external genitalia, irrespective of their gender identity or the presence of breasts in female-to-male transsexuals. This is not the case globally: transgender prisoners are housed together in Philippine prisons. New South Wales' prisons house inmates based on gender identity (Mann, 2006) and allow them access to gender-appropriate prison garb. Other than in California, this is rarely the case in U.S. institutions. Custodial staff, including corrections officers and others who work in residential settings are usually untrained and unaware of the medical and mental health care needs of trans-men and trans-women in their institutions. The Prison Rape Elimination Act of 2003 includes clauses for the funding of appropriate training for corrections officers, but the implementation of this act has been far

from uniform (Thompson, Nored, & Cheesem, 2008).

It should also be kept in mind that with deinstitutionalization of the mentally ill in many western countries, most notably the United States, prisons have become the de facto psychiatric institutions, with high percentages of incarcerated persons having one or more major mental illnesses (Allen & Rich, 2007; Davies, 2007). Persons with GID need to be evaluated for the presence of other major psychiatric disorders (Cole, O'Boyle, Emory, & Meyer, 1997), as case reports indicate that the concurrence of psychosis and GID, or gender dysphoric symptoms, may be associated with genital self-harm (Agoub, 2000; Duggal, Jagadheesan, & Nizamie, 2002; Gossler, Vesely, & Friedrich, 2002; Habermeyer, Kamps, & Kawohl, 2003; Martin & Gattaz, 1991; Myers & Nguyen, 2001; Mellon, Barlow, Cook, & Clark, 1989; Nakaya, 1996; Novak-Grubic & Tavcar, 2002; O'Gorman, 1980; Springer, 1981). It is also clear that, in the absence of psychiatric comorbidities, that autocastration in the form of surgical self-treatment for GID occurs in institutionalized persons who do not have, or are denied, access to appropriate transgender health care (Brown, 2007).

Conceptual Changes

I suggest that the following changes be made in the next revision of the *SOC*:

1. Change section title (to reflect broader scope) to "Evaluation and Treatment of Institutionalized Persons with Gender Identity Disorders."
2. Move this section out of the "Hormonal Treatment of Adults" section and situate it as a stand-alone section ("Evaluation and Treatment of Institutionalized Persons with GID") at the end of the *SOC*, since it is not specific to any one type of treatment and does not readily "fit" into any of the sections as Version 6 is currently configured.
3. Include antidiscrimination language, to ensure that triadic treatment and psychotherapy are considered on their medical merits and individualized to the institutionalized resident and his/her clinical needs, irrespective of the type of housing a person inhabits.
4. Make a clear statement to the effect that institutionalization does not, in and of itself, change the psychological, medical, and surgical needs that persons with GID may have, nor does it rule out any aspect of treatment for GID that would otherwise be appropriate if they were not institutionalized.
5. Include a statement regarding the nonmedical challenges faced by persons with GID in institutions, which include prisons and residential treatment facilities (e.g., domiciliaries within the Department of Veterans Affairs, group homes, residential rehabilitation facilities). These include the issues of safe housing, the potential for physical and sexual assault from other residents as well as caretakers, and privacy issues (Prison Rape Elimination Act, 2003; Mann, 2006).

Content Changes

I recommend that the following content changes be made in the next revision of the *SOC*:

> **Section XX. Evaluation and Treatment of Institutionalized Persons with Gender Identity Disorders.** The Standards of Care in their entirety apply to persons with gender identity disorders irrespective of their housing situation. Persons with GID should not be discriminated against in their access to appropriate transgender mental, medical, and surgical health care based on where they live, including institutional environments (e.g., prisons, domiciliaries, and other long-term or intermeditate term health-care facilities).

All elements of triadic treatment and psychotherapy as described in these SOC can be provided to persons living in institutions. If the in-house expertise of health-care providers in the direct or indirect employ of the institution does not exist to evaluate and/or treat persons with

GID, it is appropriate to obtain outside consultation from professionals who are knowledgeable in this specialized area of health care. Persons with GID in institutions may have other psychiatric disorders in addition to GID, and these conditions should be evaluated and treated appropriately as well.

Persons who enter an institution on an appropriate regimen of cross-sex hormonal treatment(s) should be continued on the same, or similar, treatment(s) and monitored according to these SOC. A "freeze frame" approach is not considered appropriate care in most situations. Persons diagnosed with GID and deemed appropriate for cross-sex hormonal treatment(s) following these SOC should be started on such treatment(s), just as are patients in noninstitutional environments. All phases of triadic treatment, and psychotherapy when deemed appropriate, can be accomplished in institutions; denial of access to these medically necessary treatments should not be on the basis of institutionalization or housing arrangements.

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with these SOC if such accommodations do not jeopardize the delivery of medically necessary care to appropriately diagnosed persons with GID. An example of a reasonable accommodation is the use of injectable cross-sex hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely. There is some evidence that parenteral estrogen treatments may be safer than oral preparations especially in people over 35 years of age. Denial of access to treatments, including SRS and the opportunity to complete the RLE, based on residence in an institution is not reasonable accommodation under these SOC.

Housing and shower/bathroom facilities for transgendered persons in institutions should take into account their transition status, dignity, privacy, and personal safety. Placement in a same-sex housing unit, ward, or pod based solely on the appearance of the external genitalia may not be appropriate and may place the patient at increased risk for both physical and sexual victimization.

CONCLUSION

The inclusion of a brief statement on access to transgender health for incarcerated persons in Versions 5 and 6 represented an initial step in addressing this issue for this stigmatized and generally disenfranchised population of persons with GID. Based on misinterpretations of the intent, and the content, of this paragraph to inappropriately limit access to evaluation and treatment for institutionalized persons with GID, as well as transgender persons without this diagnosis, it is clear that this section needs to be substantially improved in both concept and content if the intentions of the *SOC* are to address health-care access issues in these vulnerable populations. This article provides specific suggestions for conceptual and content improvements for consideration in the next version of the *SOC*.

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Recommended Revisions to the World Professional Association for Transgender Health's *Standards of Care* Section on Medical Care for Incarcerated Persons with Gender Identity Disorder

George R. Brown

ABSTRACT. The introduction of comments regarding the care of persons with gender identity disorder (GID) residing in prison settings began in 1998 with Version 5 of the *Standards of Care* (*SOC*), the first major revision of the *SOC* since 1985. Minor revisions to this brief section were made for Version 6 in 2001. Since 2001, there have been many legal and regulatory actions in countries where the *SOC* are widely used as the minimum standards to evaluate and treat persons with GID that have referenced this section in the *SOC*. The original paragraph addressing care for incarcerated persons has proven to be helpful by its existence, but limiting in its brevity and lack of scope. Version 7, likely to be a significant revision compared with the minor changes in Version 6, can be informed by the information that has come to light in the last 6 years, most notably through court actions that have used, or misused, the *SOC*. This invited article reviews the background of this section, rationale for revisions, suggested conceptual changes, and specific content for consideration for inclusion in Version 7 of the *SOC*.

KEYWORDS. Incarceration, autocastration, gender identity disorder, standards of care

Although the majority of persons with gender identity disorder (GID) are marginalized members of most societies, those who are in institutions, including prisons, are doubly so, but no less deserving of compassionate, appropriate health care (Blight, 2000; More, 1996). Indeed, the Eighth Amendment to the U.S. Constitution prohibits cruel and unusual punishment of prisoners in the United States, with case law interpreting this to also mean that "adequate medical care" is guaranteed for those who are incarcerated. The irony in this for Americans is that institutionalized persons have a legal right to health care that is not shared by those in the general population. This reality likely contributes to the difficulty that transgender persons often face with accessing health care and other services in institutional settings. The further refinement and interpretation of the term "adequate" is constantly up for debate and is generally decided by courts, not by clinicians.

Persons diagnosed with GID are a subset of persons who identify as transgender. Although there remains some controversy and evolving debate in consumer and professional circles over whether GID should continue as a psychiatric diagnosis, a "medical" diagnosis, or no diagnosis at all, at the time of this writing GID is a

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The views expressed in this article are those of the author and do not necessarily represent those of the US Government or the Department of Veterans Affairs.

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well-described, formal diagnosis in DSM-IV-TR, and the terminology of the American Psychiatric Association for GID will be used throughout this article. "Transgender" is not a diagnosis, and when used it signifies an umbrella term for any persons who have a gender identity that is variant from the traditional dichotomous masculine and feminine identifications. These individuals may, or may not, have a gender-related diagnosis but may be in need of specialized evaluations and/or medical care.

One of the missions of the WPATH is to advocate for nondiscriminatory, appropriate health care for persons with transgender conditions, independent of HIV status, where they live, their race, their social position, or other demographic variables, unless there is a clinical indication to provide services in a different fashion (Meyer et al., p. 2): "Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol." The majority of persons who meet the SOC for hormonal and surgical intervention would have gender dysphoria and would often meet the current criteria for GID. Therefore, the focus of this article is on those with a diagnosis for whom treatment is well described, although some persons who do not meet criteria for a diagnosis of GID may also benefit from the treatment(s) described in the *SOC*.

Silence on the issues of discrimination against institutionalized persons with GID in the current *SOC* have been misinterpreted by healthcare providers, including some current and past members of WPATH, and administrators of institutions or health care plans to mean that there is a tacit approval of some forms of discrimination since these issues are not specifically addressed (e.g., Kosilek v. Mass. Dept. of Corr., 2002). There is wide variation in the application of the current SOC to institutionalized persons with GID. This variation was documented many years ago in a survey of prison transgender health-care policies by Petersen, Stephens, Dickey, and Lewis (1996). I am unaware of more recent surveys of this issue (a survey by the late Gianna Israel, 2002, documented inmate perspectives but did not collect responses from institutions or their administrations), but the included references for prison directives demonstrate that this variability is reified in institutional policies currently on the books. Variability between countries is notable as well. For example, prisoners and other institutionalized persons housed in the United Kingdom have similar access to transgender health care as they would outside of institutions, with care being provided by the National Health Service. Australian prisoners have less access to transgender health care, but with the advocacy of therapists, they are able to access this care, including continuation of, and initiation of, cross-sex hormonal treatments. Persons with GID incarcerated in Brazil have access to transgender health care, including the potential for SRS. One Canadian inmate has been able to access SRS on a self-pay basis.

Strategies used by institutions, some governments, and third-party payers to deny care for institutionalized persons that could otherwise be available for properly diagnosed persons with GID include:

1. Using what the *SOC* do NOT say as a method of denial of care access
2. Placement of the current section on prisoner care (which is too limited in scope) under the hormonal-treatment section has been used to deny care to those in institutions who may need types of care for their GID other than cross-sex hormones
3. Rigid interpretations of the current section to deny care to those who may enter an institution and need treatment started de novo after entry, as opposed to merely continuing existing treatment (sometimes in an ill-conceived "freeze frame" approach that limits transition status to exactly what it was at entry to an institution, even if the expected duration of stay at the institution may be for an extended period of time, up to the remainder of the person's life) (It should be noted that courts have struck down the "freeze frame" approach as not taking into account the individualized health care needs of persons with GID in institutions [see, for example, Kosilek v. Mass Dept. of Corr., 2002].)

4. The limiting of the current *SOC* to "incarcerated persons," as opposed to using more inclusive language, such as "institutionalized persons"
5. Lack of a literature base supporting, or not supporting, the provision of triadic care, in all or in part, for institutionalized persons
6. The belief, not supported by objective fact, that the Real Life Experience (RLE) cannot possibly be negotiated by someone living in an institution, even if that environment is the patient's "real life" circumstance for an extended period of time (This has been used as a way to render a "blanket denial" of any request for surgical intervention by stating that the person cannot ever be referred for surgery because, by this misinterpretation, a RLE cannot possibly occur in an institution.)
7. Basing housing arrangements on the appearance of external genitalia as opposed to taking into consideration the gender role and other clinical circumstances of the resident.

In the current verson of the *Standards of Care* (Version 6), the brief section on the issue is included under Section VII, "Requirements for the Hormonal Treatment of Adults" states the following:

> **Hormone Therapy and Medical Care for Incarcerated Persons**
> Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

RATIONALE FOR REVISIONS

The following points describe the author's rationale for the recommended revisions:

- Current placement of this guidance under the hormones section seems to imply that hormonal treatment is the only issue at stake for institutionalized persons, and that is clearly not the case. Access to the full spectrum of potential treatments, including psychotherapy, must be addressed.
- Lack of comment in this brief section on issues regarding other treatments, including triadic therapy in general, keeps this population vulnerable and unable to access treatments as an unintended consequence of the "silence" on these issues in the current *SOC*.
- Accumulation of case law and use of the *SOC* in various courts since the publication of Version 6 informs us more and enables us to consider modern revisions for this section. I have included some references at the end of this article in support of this statement. For example, at least one major court case at the federal-district-court level in the United States (Kosilek v. Mass. Dept. of Corr., 2002) ruled that:

  1. GID is a serious medical need warranting treatment, even in prison.
  2. The Real Life Experience is possible in a prison setting.
  3. Treatment for persons with GID should be individualized, with no "blanket denials" of care for incarcerated persons properly diagnosed with GID.
  4. Hormones could be started de novo for prisoners if medically appropriate, with determination of medical need to be made by health care providers and not by administrators.
  5. Natal males with GID in a prison setting could have access to the same items as other females in the state's

> institutions, e.g. cosmetics, female undergarments, longer nails and hair, and "unisex" prison clothing.

As a result of this 2002 ruling in a U.S. federal district court, an inmate with GID diagnosed by nearly a dozen professionals with expertise in evaluating and treating GID received access to de novo cross-sex hormones, female undergarments, laser electrolysis, cosmetics, and the opportunity to be evaluated for SRS.

These same issues are playing out across the United States and in numerous states at the time of this writing. Legal name changes for natal males to female names are generally not impeded. Provision of hormonal treatment in some institutions is highly variable. Some states allow for only continuation of treatments at the same levels as entry into an institution (e.g., the Colorado Department of Corrections), while others allow for both continuation and for de novo initiation of cross-sex hormonal treatments (e.g., the Wisconsin Department of Corrections, Idaho Department of Corrections, Federal Bureau of Prisons, and California Department of Corrections). The case of *Burt v. Hawk* (1996/1998) is an example of de novo initiation of cross-sex hormonal treatment for a prisoner in federal custody; the case of *Kosilek v. Massachusetts Department of Corrections* (Maloney) is an analogous case for initiation of cross-sex hormone treatment in a state prison. It should be noted that although de novo initiation of cross-sex hormones may be allowed in institutional settings, these directives are not always complied with (Brown, 2007).

Lack of access to transgender health care in institutions has caused, or contributed to, serious negative health outcomes including depression, exacerbation of other mental illnesses, suicidal thinking and behavior, and autocastration and/or autopenectomy (Blacker and Wong, 1963; Brown, 2001, 2003, 2007; Catalano, Morejon, Alberts, & Catalano, 1996; Conacher & Westwood, 1987; Haberman & Michael, 1979; McGuire, Ahmed, & Nazeer, 1998; Nakaya, 1996; Novello & Primavera, 1990; Springer, 1981). Indeed, the early work of Abraham on two of the earliest cases of SRS noted:

> It was not easy for us to decide on the described procedures, but the patients were not to be dismissed, but also were in a mental state that made it probable that self-mutilation, with life-endangering complications, could be possible. (Abraham, 1997; translated from the original 1931 German text)

Abrupt discontinuation of cross-sex hormonal treatments (e.g., in Wisconsin prisons after the passage of Act 105 by the Wisconsin legislature in late 2005, prohibiting hormonal and surgical treatment of inmates in the Wisconsin Department of Corrections) can result in negative health outcomes as well, including the previously mentioned symptoms and involution of acquired secondary sexual characteristics, which in turn exacerbate depression, gender dysphoria, emotional lability (Brown, 2001). While medical care issues are the focus of much of the *SOC*, it cannot be overemphasized that institutionalized (not only incarcerated) persons with GID and other persons with transgender issues face problems related to safe-housing arrangements, potential for sexual and physical assault, and difficulties with access to standard programming like substance-abuse group counseling in a residential setting. The placement of transgender persons in institutions is often problematic, and usually based on anatomy. For example, state and federal prison systems in the United States place inmates with others who have the same external genitalia, irrespective of their gender identity or the presence of breasts in female-to-male transsexuals. This is not the case globally: transgender prisoners are housed together in Philippine prisons. New South Wales' prisons house inmates based on gender identity (Mann, 2006) and allow them access to gender-appropriate prison garb. Other than in California, this is rarely the case in U.S. institutions. Custodial staff, including corrections officers and others who work in residential settings are usually untrained and unaware of the medical and mental health care needs of trans-men and trans-women in their institutions. The Prison Rape Elimination Act of 2003 includes clauses for the funding of appropriate training for corrections officers, but the implementation of this act has been far

rom uniform (Thompson, Nored, & Cheesem, 008).

It should also be kept in mind that with de-nstitutionalization of the mentally ill in many vestern countries, most notably the United tates, prisons have become the de facto psy-hiatric institutions, with high percentages of ncarcerated persons having one or more major ental illnesses (Allen & Rich, 2007; Davies, 007). Persons with GID need to be evalu-ted for the presence of other major psychi-tric disorders (Cole, O'Boyle, Emory, & Meyer, 997), as case reports indicate that the concur-ence of psychosis and GID, or gender dyspho-ic symptoms, may be associated with genital elf-harm (Agoub, 2000; Duggal, Jagadheesan, Nizamie, 2002; Gossler, Vesely, & Friedrich, 002; Habermeyer, Kamps, & Kawohl, 2003; lartin & Gattaz, 1991; Myers & Nguyen, 001; Mellon, Barlow, Cook, & Clark, 1989; akaya, 1996; Novak-Grubic & Tavcar, 2002; 'Gorman, 1980; Springer, 1981). It is also clear at, in the absence of psychiatric comorbidities, at autocastration in the form of surgical self-reatment for GID occurs in institutionalized per-ons who do not have, or are denied, access to ap-ropriate transgender health care (Brown, 2007).

onceptual Changes

I suggest that the following changes be made the next revision of the *SOC*:

1. Change section title (to reflect broader scope) to "Evaluation and Treatment of Institutionalized Persons with Gender Identity Disorders."
2. Move this section out of the "Hormonal Treatment of Adults" section and situate it as a stand-alone section ("Evaluation and Treatment of Institutionalized Persons with GID") at the end of the *SOC*, since it is not specific to any one type of treatment and does not readily "fit" into any of the sections as Version 6 is currently configured.
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CONCLUSION

The inclusion of a brief statement on access to transgender health for incarcerated persons in Versions 5 and 6 represented an initial step in addressing this issue for this stigmatized and generally disenfranchised population of persons with GID. Based on misinterpretations of the intent, and the content, of this paragraph to inappropriately limit access to evaluation and treatment for institutionalized persons with GID, as well as transgender persons without this diagnosis, it is clear that this section needs to be substantially improved in both concept and content if the intentions of the *SOC* are to address health-care access issues in these vulnerable populations. This article provides specific suggestions for conceptual and content improvements for consideration in the next version of the *SOC*.

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EXHIBIT

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Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder

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ABSTRACT. The author reports on a case series of four inmates who engaged in attempted or completed surgical self-treatment of their gender dysphoria via autocastration, autopenectomy, or a combination in the absence of concomitant psychosis, intoxication, or other comorbidities that could reasonably account for this rare behavior. These behaviors occurred in the context of persistent denials of access to transgender health care in prison settings. The literature on genital self-harm is also reviewed. Incarcerated persons with severe GID may resort to life-threatening surgical self-treatments when persistently denied access to psychiatric evaluation and cross-sex hormonal treatment. In all cases of surgical self-treatment (SST; i.e., autocastration with the primary intent to reduce circulating testosterone levels) the intensity of gender dysphoria decreased compared to reported baseline levels, although symptoms of GID were still present. Of the four inmates, two were able to obtain access to cross-sex hormones after successful litigation at the time of this writing; another was not. One case remains active. This case series expands the limited literature on surgical self-treatment in the form of autocastration and autopenectomy with a focus on the potential influence of incarceration with denial of access to transgender health care.

KEYWORDS. Transsexual, incarceration, autopenectomy, autocastration, surgical self-treatment, gender identity disorder

Many natal males with gender identity disorders (GID; American Psychiatric Association, 2000, 302.85) are known to harbor thoughts or wishes regarding the removal of their testicles and, to a lesser extent, their penises at some time during the course of their disorder (Brown, 1990, 2001, 2003; 2007; Brugman & Collumbien, 1994). The majority of persons with GID, however, never act on these feelings, especially if they have access to appropriate evaluation and management of their condition. With the advent of access to cross-sex hormones through quasilegal means on the Internet or access via illegal diversions or drug sharing, completion of autocastration and/or autopenectomy are rare behaviors in nonimprisoned persons. These behaviors are associated with very few psychiatric disorders. A review of the English- and German-language literature over the past century reveals at least 125 cases of male genital mutilation (Catalano, Catalano, & Carroll, 2002; Springer, 1981) since an initial

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report by Stroch in 1901. Of these cases, at least 62 persons completed autocastration in association with (a) schizophrenia (Agoub, 2000; Agoub & Battas, 2000; Cooper & Swamy, 1994), (b) gender identity disorder or transsexualism (Haberman & Michael, 1979; Springer, 1981), (c) obsessive-compulsive disorder (single case report; Yang, Chen, & Chen, 2006), (d) bipolar disorder (Habermeyer, Kamps, & Kawohl, 2003), (e) paraphilia, or (f) personality disorder with or without comorbid substance abuse at the time of the genital self-injury. In the largest case series published on autocastration, Springer reported that he was able to document 37 cases in the English- and German-language literature between 1901 and 1981 (Springer, 1981), one of which was evaluated by him. Over half were attributed by the authors of the collected case reports to transvestism or transsexualism. The term transsexualism did not come into common usage until the 1960s, long after many of the early cases were reported; therefore, a clear diagnostic distinction cannot be made. When genital mutilation without the intent to remove the genitals is separated from those who engage in autocastration and autopenectomy, the primary diagnoses for those who intend to remove their genitals are further reduced to (a) GID (transsexualism), (b) bipolar mania, (c) schizoaffective disorder, (d) schizophrenia (with psychosis at the time of the act in the last three diagnoses but not in the first diagnosis) and comorbid psychotic disorder and GID with or without concomitant substance use disorder (Cole, O'Boyle, Emory, & Meyer, 1997; Novak-Grubic & Tavcar, 2002), or, rarely, (e) paraphilia other than transvestism (e.g., sexual masochism, Springer, 1981, chapter 7, p. 12). Autocastration has also been reported to occur just before a "first break" psychotic episode (Myers & Nguyen, 2001).

As with other types of self harm, it is important to understand the intent of genital self-harm for a given patient who engages in this behavior (Walsh & Rosen, 1988, p. vii-ix). Persons with GID often describe being repulsed by the presence of their genitalia and wish to have them removed as part of their overall transition from male to female. They may also discuss a desire to reduce testosterone by elimination of the main organs producing this "offending" circulating hormone. In this sense, patients with GID may engage in fantasized actual autocastration as a type of "surgical self-treatment" (SST), especially if they do not have access to appropriate medical care, e.g., cross-sex hormonal treatment and/or sex reassignment surgery (SRS). The term "genital mutilation," often referred to in the literature (Catalano, Morejon, Alberts, & Catalano, 1996; Martin & Gattaz, 1991; McGuire & Ahmed, 1998; Novello & Primavera, 1990), would therefore not be accurate for patients who engage in SST with the conscious, reasoned, intention to reduce testosterone levels in the absence of evidence of active psychosis when other less invasive alternatives are unavailable. Genital mutilation would appropriately refer to the infliction of pain or damage to one's genitalia for purposes other than such self-treatment. Genital mutilation, distinct from SST, has been reported in persons with personality disorders (Sockalingam & Stergiopoulous, 2005), psychotic disorders (Agoub, 2000; Cooper & Swamy, 1994; Gossler, Vesely, & Friedrich, 2002) and paraphilias (Money, 1988; Springer, 1981). It is likewise inaccurate to describe SST as a suicide attempt as this is not the intent of those who autocastrate, even in the context of psychosis (Blacker & Wong, 1963). Irrespective of the lack of intent to end their lives, persons who engage in this behavior may inadvertently die due to severe blood loss and hemodynamic collapse. Most of the individuals who autocastrate do not appreciate the elasticity of the testicular arteries. These arteries can quickly retract into the peritoneum, making self-hemostasis of the wound nearly impossible.

Autocastration in prison settings is most often associated with a primary diagnosis of GID that is undiagnosed and untreated, with numerous examples of such behaviors occurring in corrections facilities in multiple countries (Blight, 2000; Brown, 2003, 2007; Conacher & Westwood, 1987; More, 1996). This author has firsthand knowledge of cases of SST or other genital harm in five separate corrections facilities in Idaho, Wisconsin, Massachusetts, and Virginia. The co-occurrence of gender dysphoria and psychotic disorders is also reported, and one condition does not "protect" against the other. Therefore, patients may have both schizophrenia or bipolar disorder and gender dysphoria symptoms or threshold diagnosis

GID. Gender dysphoria may be an uncommon symptom in patients with a primary psychotic disorder (Mayer & Kampfhammer, 1995). Analytic theories of the past have held that gender dysphoria may represent a type of psychosis in and of itself (Siomopoulos, 1974), or a form of symbolic suicide (Menninger, 1938), but these theories have generally not held sway in modern psychiatric theories on the nature of GID (Brown, 2001). Generally, when gender dysphoria is present in patients without GID but with a psychotic disorder, the intensity of the gender dysphoria and risk for genital amputation is increased while they are in a psychotic state, but not necessarily when they are in remission from their primary psychotic symptoms. Patients with comorbid diagnoses of GID and a psychotic disorder display gender dysphoric symptoms while they are in remission from psychotic symptoms. In either situation, SST (autocastration, autopenectomy, or both) is a high risk, potentially lethal, possibly preventable, outcome of failing to appropriately address these serious symptoms whether the patient has a psychotic disorder with or without a diagnosis of GID. The combination of the two diagnoses would appear to represent the highest risk for serious genital amputation(s) (Mellon, Barlow, Cook, & Clark, 1989) whether in a prison setting or elsewhere, although data to support this hypothesis are lacking.

METHODS

Over the past 11 years, the author has received correspondence from 18 incarcerated persons claiming to have symptoms of gender dysphoria and requesting assistance with obtaining access to transgender health care in the form of evaluation, medical care, or both. Eight had claimed to have engaged in SST; five others indicated they were seriously considering such action. Of this group, five provided consent to be evaluated by the author, three of whom had completed autocastration (two with autopenectomy as well). All of these inmates had engaged in serious genital self-harm after incarceration but not before; one had inserted a needle into the urethra as a teenager in the reported belief that this would somehow make the doctors remove her penis. The three cases of completed autocastration are summarized below with alterations in demographic information to protect their identities. All were natal males and will be referred to by their preferred (female) pronouns consistent with clinical convention (Brown, 1990). Detailed medical, administrative, and mental health records were available for each inmate.

RESULTS

The case summaries and outcomes are described below. The initials do not correspond to those of any of the patients' real names.

Case AA

AA is a 52-year old natal male incarcerated in a western state for about 8 years. Prior to incarceration, she had been alcohol dependent and had engaged in a number of nonviolent crimes. She had reportedly suffered from gender dysphoric symptoms for years prior to this incarceration and requested an evaluation and treatment for gender identity disorder shortly after she was imprisoned. She had engaged in cross-dressing and had self-administered illicitly obtained cross-sex hormones intermittently prior to imprisonment. At the time of the index incarceration, there was no directive or guidance in this state to assist the Department of Corrections (DOC) health care staff in how to address potential GID in inmates. She was therefore denied access to both an evaluation and treatment by the warden of the institution. Upon receipt of this written denial, she gave verbal and written warnings to prison officials that she would autocastrate if she did not get evaluated for GID by an experienced mental health care provider. Prison officials documented that they viewed this as manipulative behavior for an unspecified secondary gain and continued to deny her access to an evaluation. When it became clear to the inmate that she would not be provided access to transgender health care, she cut off her testicles with a razor blade and flushed them down the commode. She was admitted to a local hospital and received numerous transfusions and surgical

interventions. She recovered and was returned to prison. Shortly thereafter, she informed DOC officials that if she did not receive an evaluation and treatment for GID symptoms, she would also autopenectomize in one year's time. At the end of one year, no assessment or treatments were forthcoming, and she amputated her penis and flushed it down the commode, necessitating another acute inpatient hospitalization and multiple blood transfusions. Legal intervention resulted in her transfer to another state for evaluation and treatment (which included cross-sex hormones) and a legal settlement with the DOC that, in part, established a new directive for the management of inmates in that state who claim to have GID. The cash settlement she was awarded was and is still the largest ever awarded to a prisoner in that state. Following SST, her symptoms decreased, and she did not regret "cutting off my stuff." She was later released after the completion of her sentence, but continued to live a marginalized life as a homeless person, unable to secure employment as a woman.

Case AB

AB is a 33-year old Caucasian natal male inmate incarcerated for a violent crime in a western state for at least 20 years to life with the possibility of parole at some time in the future. She reported verbal abuse and neglect by her mother and a series of abusive stepfathers while she was growing up. She was a veteran of the U.S. Army (2½ years) and was discharged prematurely "under honorable conditions" due to illicit drug use. She had a long history of mental illness with diagnoses to include paranoid schizophrenia, obsessive-compulsive disorder, bipolar disorder, and schizoaffective disorder recorded in her medical files, along with substance abuse. After incarceration, she initiated numerous written requests for an evaluation of her gender dysphoric symptoms. She described herself as "feeling like a hermaphrodite," and it was clear that she had little knowledge of the language of transsexualism or GID initially, but that she was expressing gender dysphoria and desire for cross-sex hormonal treatment. This was recorded by her in at least 75 written correspondences to the prison staff. She was denied access to an evaluation for GID but was treated for comorbid conditions with variable results, which included resolution of psychotic symptoms which were flagrant during the first months of her incarceration. She went on frequent hunger strikes to protest her treatment in prison, sometimes necessitating force-feeding. Her gender dysphoria persisted for years in spite other conditions being in remission, and she continued to request evaluation for GID. She changed her name to a female name while in prison. After at least two years of trying to obtain an assessment, she planned and followed through on autocastration. She flushed the testicles down the commode and was treated for significant blood loss at a local hospital. Detailed records by numerous observers in two institutions and in the ambulance did not detect any evidence of a thought or mood disorder before, during, or after this SST. No psychotic behavior was observed. Likewise, there was no evidence of substance use or intoxication that had occurred recently or during the autocastration. She was returned to prison, placed in solitary confinement on "suicide watch" but did not receive any assessment for GID. No alternative diagnostic theory was documented by DOC health care providers. She was offered intramuscular testosterone, which she refused to consider, pointing out that the purpose of autocastration was to eliminate testosterone. Nine months later, again in a clear mental state according to records, she amputated half of her penis and flushed it down the commode, preserving the other half as she believed it would be needed for SRS in the future. Over a year after this second genital self-surgery, she had yet to be evaluated for GID; she expressed no regrets whatsoever regarding her SST's and indicated that the severity of her gender dysphoria had abated somewhat. She is currently receiving no treatments for GID and litigation over this issue is ongoing. She also continues to go on intermittent, lengthy hunger strikes in protest.

Case AC

AC is a 26-year old Caucasian natal male incarcerated in a western state for property crimes and a subsequent brief escape from prison. She reported prolonged sexual abuse at the hands

of an adult male family friend before and after the onset of puberty. She engaged in repeated criminal activities, heavy drug abuse, and sexual offenses against minors when she was a teenager. She stated she used illicit hormones prior to incarceration and lived as a woman with a heterosexual male for nearly a year, although some of these statements are not verifiable. Diagnoses before incarceration at age 20 were limited to conduct disorder, antisocial personality disorder, substance abuse, and attention deficit-hyperactivity disorder. There was no history of a mood or thought disorder. The inmate petitioned the DOC for an evaluation of her long-standing gender dysphoria following the applicable DOC directive and was repeatedly denied access to a specialist in transgender health care. She accepted a transfer to a maximum security facility (even though her crimes did not warrant this placement) in order to obtain access to an evaluation and the potential for cross-sex hormonal treatment. She legally changed her name in prison, grew her hair and nails long, modified her prison garb to a more unisex appearance, and persistently presented herself as having symptoms consistent with GID. When it became clear to her that the DOC mental health treatment team was denying her access to transgender health care, absent an appeals process, she used a razor blade to remove both of her testicles and flushed them down the commode. Numerous chart notes from multiple health care providers in two institutions as well as ambulance personnel revealed no evidence of psychosis or intoxication before, during, or after self-surgical treatment. She provided a written, contemporaneous explanation of her actions: "I cut my genitals off do [sic] to the fact that I am a transgenderd [sic] individual and I could stand the sight of them no more. This is not a suicide attempt. This is simply a way for me to remmady [sic] my problem."

She was treated for hypovolemia and anemia at a local hospital and then returned to the prison. There was no change in the treatment plan, and no apparent consideration was given to the diagnosis of GID according to the records. Nearly two years after the surgical self-treatment, the inmate is pleased with the changes that have occurred in her body and psyche and she does not regret SST. She has been offered intramuscular testosterone by DOC physicians to address the osteoporosis inherent in the lack of circulating sex steroid hormones. The inmate has refused this intervention noting that the reason she engaged in SST was to reduce her testosterone levels. Recently, as a result of litigation, she has been started on a cross-sex hormonal regimen and is slated for early release on parole.

DISCUSSION

Autocastration and autopenectomy in natal males are complex behaviors with several potential underlying motivations (Menninger, 1938; Nakaya, 1996; Springer, 1981). Catalano et al. (2002), drawing upon the prior work of Blacker and Wong (1963), Greilsheimer and Groves (1979), and Martin and Gattaz (1991), listed 10 risk factors for "genital self mutilation": psychosis, alcohol intoxication, homosexual or transsexual feelings, guilt feelings for sexual offenses (real or imagined), separation or failure experiences, lack of responsiveness by health care providers to their requests for surgical castration, and a past history of genital self-mutilation. These characteristics were described in persons living in the community, but clearly there is overlap with this case series of incarcerated persons with GID. The main difference applicable to incarcerated persons with GID is that these patients frequently do not have access to psychiatric evaluations by those with experience in the assessment of persons with GID, let alone cross-sex hormonal treatment or sex reassignment surgery (Brown, 2003, 2007). With no other viable options, severe gender dysphoria in prisons that do not provide transgender health care may lead to desperate measures of self-treatment through permanent removal of the testes and/or penis in the absence of comorbid psychosis or substance use disorders. Abrupt cessation of estrogen treatment upon incarceration, not infrequently reported by inmates, can also lead to emotional instability, a reoccurrence of severe gender dysphoria, hopelessness, and the potential for genital harm and/or SST. The case reports described above indicate that SST is generally not spontaneous and is preceded by substantial efforts, both verbal and written,

at obtaining psychiatric and medical care for gender dysphoria. Without formal evaluation by experienced mental health clinicians, an individualized treatment plan following the World Professional Association for Transgender Health Standards of Care cannot be crafted or implemented. Even in the relatively Spartan and supposedly secure environment of a prison, motivated gender dysphoric inmates are still able to remove their testicles, penis, or both when they lose hope of access to transgender health care. This leaves them at risk for potential unintentional fatal hemorrhage. Although reliable data do not exist, it is likely that the probability of SST by incarcerated persons with GID substantially exceeds that seen in GID populations who have access to transgender health care. In this author's nearly three decades of experience evaluating hundreds of persons with GID, only one case of completed (unilateral) autocastration was encountered from a population of nonincarcerated gender dysphoric persons. This patient had a primary diagnosis of schizophrenia with secondary gender dysphoric symptoms while psychotic. He used a pneumatic nail gun to "shoot" one of his testicles and then reported to an emergency room with his testicle and scrotum nailed to a wooden chair. When his psychosis was controlled, he did not express a wish to harm his genitals.

As noted in some of the references included in the introduction, SST of gender dysphoria outside of prison settings has been reported, as access to transgender health care is by no means universal, available, or affordable in many countries, notably the United States. However, resourceful gender dysphoric persons are often able to obtain cross-sex hormones by illicit or legal means, which may obviate the need for more desperate attempts at SST (Brown, 2003). Persons with GID in prison settings generally do not have the ability to seek other alternatives for relief of severe gender dysphoria if they are denied access to treatment. The length of the inmate's sentence may also be a correlate of engaging in SST but there are not enough data to test this hypothesis.

The cases illustrated above should alert both prison officials and health care providers in prison settings to the possibility of life-threatening SST in their inmate populations with alleged or diagnosed severe gender dysphoria. In all three of these cases, the inmates communicated their feelings of gender dysphoria and their requests for psychiatric and medical evaluation for GID. In all cases, access to appropriate evaluation and treatment was denied by prison officials prior to any of the inmates engaging in SST or genital harm. Some prison systems now have directives in place that are supposed to provide for an evaluation of inmates who claim to be transgendered individuals (e.g., California Department of Corrections and Rehabilitation, 2007; Idaho Department of Corrections, 2003; Wisconsin Department of Corrections, 2002), with the possibility of obtaining consultative services from health care providers experienced in evaluation and management of GID. Such policies are by no means universal, nor are they necessarily implemented when they do exist. Many states' Departments of Correction provide no guidance on this issue as of late 2007 (e.g., Maine, Mississippi, and Rhode Island); some actually prohibit the provision of evaluation for gender identity disorder other than confirming a preexisting diagnosis prior to incarceration (e.g., Washington State Department of Corrections, 2006).

In prison settings where access to cross-sex hormonal treatment is a reasonable expectation as part of transgender health care for appropriately diagnosed inmates, SST is not reported (Denise Taylor, MD, & Lori Kohler, MD, personal communications, December 2007), which further supports the theory that the relevant issue underlying SST is lack of access to transgender health care and not incarceration itself. Departments of Correction that routinely block access to cross-sex hormonal treatments for GID have been subjected to protracted litigation and its attendant costs, as well as financing emergency room/ICU care for inmates who must be treated emergently when they engage in SST. Ironically, Departments of Correction will spend far more taxpayer dollars preventing access to transgender health care than they would if they provided appropriate, nonemergent care following the WPATH Standards of Care for the small number of incarcerated persons with GID.

A 1996 survey of 64 prison systems in North America, Australia, and Europe (Petersen,

Stephens, Dickey, & Lewis, 1996), the most recent published survey of its kind, revealed that only 20% of facilities had any formal policies addressing transgender health care and housing and another 20% had "informal" policies. In the United States, that number has risen in the last decade to at least 18 states, the Federal Bureau of Prisons, and the District of Columbia (2007 Freedom of Information responses from 23 states; 27 states did not respond to the request for information), with the majority of the directives effective after 2000. Some of these directives or policy letters are simply to clarify that no transgender health care will be provided without SRS having been completed prior to incarceration and that cross-sex hormones prescribed at the time of incarceration will be discontinued under all other circumstances (e.g., Florida Department of Corrections, 1995; Kansas Department of Corrections, 2003), or "maintained" at the same "transgender status" as the inmate was upon incarceration (Georgia Department of Corrections, 2001). In 2000, the Australian Institute of Criminology published a review of the Australian state policies on transgender inmates. The report concluded,

> Transgender inmates present a unique set of issues that, if not appropriately dealt with, could lead to a greatly increased incidence of assault and self-harm in that population. Failure to implement appropriate policies may also amount to a breach of antidiscrimination legislation and/or human rights obligations. (Blight, 2000)

In the United States, the point prevalence of incarcerated persons (excluding municipal jails) with GID may be between 2 and 400 per state, with the largest states (e.g., California, New York, Florida, and Texas) having the greatest number at any given time. Although precise figures are not known, a reasonable estimate is that there are between 500 and 750 inmates in custody in state facilities and possibly another 50 to 100 in federal facilities. It is estimated, for example, (based on court documents) that approximately 7 to 9 inmates in Massachusetts were known to have GID in 2005, approximately 5 in Idaho in 2007, and similar numbers in Wisconsin in 2007. California is estimated to have as many as 400 transgendered inmates (including small numbers of female-to-male transgender inmates) at any given time (L. Kohler, personal communication, 2006, 2007, 2008). Many inmates are not diagnosed, making any estimates less accurate. In any event, even at the highest end of the estimates provided, this is a relatively small population compared to the 2,396,002 inmates in custody in the United States in December, 2008 (Bureau of Justice Statistics, 2008). If one uses the lower end of these rough estimates, it is still likely that persons with GID are overrepresented in prison settings. While precise population estimates of GID in the United States do not exist, using the estimate of 1/11,000 male-to-female transsexuals derived from a Dutch study of prevalence (Ketteren, Gooren, & Megens, 1996), only about 218 natal male inmates with GID would be expected in the United States when the general population is approximately 300,000,000 (with an estimated 27, 272 persons with GID) and the prison population is 2.4 million, the vast majority of whom are male. The more liberal estimates of Olyslager and Conway (1:1000 to 1:2000 live births; 2007) would result in a five- to tenfold difference in this estimate. The inmate population with GID in California alone exceeds the expected number for the entire nation if persons with GID were not incarcerated at a higher rate than the estimates of their numbers in the U.S. population. Similar conclusions of a higher prevalence of GID in the incarcerated population compared to the "free" population have been reached in Scotland, where an estimated 1:12,400 men over the age of 15 have GID (Elkins, Olagundoye, & Rogers, 2001). Poverty, social and vocational marginalization, poor psychosocial functioning, rejection by family/friends/employers, and psychiatric comorbidities are all likely to contribute to this phenomenon.

CONCLUSION

Surgical self-treatments by incarcerated persons are dramatic, potentially lethal, but possibly preventable, sequelae of denial of access to transgender mental and medical health care

in the prison setting. Early reviews of cases in the community noted common characteristics in those who engaged in SST: impoverished childhood experiences, repudiation of male genitalia, relief of depression by genital mutilation, sexual identity confusion, submissive and/or masochistic relationships with women, and intense cross-gender identifications (Blacker & Wong, 1963). Clearly, some of these descriptors applied to some of the cases presented, but it appears that the salient characteristic common to all of these cases is denial of access to appropriate psychiatric evaluation and treatment in an institutional setting where few other options existed for severely gender dysphoric inmates. SST resulted in amelioration of some symptoms of gender dysphoria when cross-sex hormonal treatment was not provided, and those who engaged in this behavior did not regret this self-surgery at one or more years after the event. SST, in all cases reported herein, occurred in the absence of active psychosis or intoxication and was planned in advance, apparently associated with a loss of hope that more traditional transgender health care would be forthcoming. Given the lethal potential, as well as the costs of emergency care and attendant litigation, departments of correction that do not provide for evaluation and individualized treatment planning should consider reviewing their approaches to the evaluation and management of inmates who report symptoms of gender dysphoria. Evolving published standards of care for the psychiatric, medical, and surgical care of persons with GID (e.g., Levine et al., 1998; Meyer et al., 2001 should be more comprehensive in addressing the health care needs of persons with GID in institutional settings.

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Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder

George R. Brown

ABSTRACT. The author reports on a case series of four inmates who engaged in attempted or completed surgical self-treatment of their gender dysphoria via autocastration, autopenectomy, or a combination in the absence of concomitant psychosis, intoxication, or other comorbidities that could reasonably account for this rare behavior. These behaviors occurred in the context of persistent denials of access to transgender health care in prison settings. The literature on genital self-harm is also reviewed. Incarcerated persons with severe GID may resort to life-threatening surgical self-treatments when persistently denied access to psychiatric evaluation and cross-sex hormonal treatment. In all cases of surgical self-treatment (SST; i.e., autocastration with the primary intent to reduce circulating testosterone levels) the intensity of gender dysphoria decreased compared to reported baseline levels, although symptoms of GID were still present. Of the four inmates, two were able to obtain access to cross-sex hormones after successful litigation at the time of this writing; another was not. One case remains active. This case series expands the limited literature on surgical self-treatment in the form of autocastration and autopenectomy with a focus on the potential influence of incarceration with denial of access to transgender health care.

KEYWORDS. Transsexual, incarceration, autopenectomy, autocastration, surgical self-treatment, gender identity disorder

Many natal males with gender identity disorders (GID; American Psychiatric Association, 2000, 302.85) are known to harbor thoughts or wishes regarding the removal of their testicles and, to a lesser extent, their penises at some time during the course of their disorder (Brown, 1990, 2001, 2003; 2007; Brugman & Collumbien, 1994). The majority of persons with GID, however, never act on these feelings, especially if they have access to appropriate evaluation and management of their condition. With the advent of access to cross-sex hormones through quasilegal means on the Internet or access via illegal diversions or drug sharing, completion of autocastration and/or autopenectomy are rare behaviors in nonimprisoned persons. These behaviors are associated with very few psychiatric disorders. A review of the English- and German-language literature over the past century reveals at least 125 cases of male genital mutilation (Catalano, Catalano, & Carroll, 2002; Springer, 1981) since an initial

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report by Stroch in 1901. Of these cases, at least 62 persons completed autocastration in association with (a) schizophrenia (Agoub, 2000; Agoub & Battas, 2000; Cooper & Swamy, 1994), (b) gender identity disorder or transsexualism (Haberman & Michael, 1979; Springer, 1981), (c) obsessive-compulsive disorder (single case report; Yang, Chen, & Chen, 2006), (d) bipolar disorder (Habermeyer, Kamps, & Kawohl, 2003), (e) paraphilia, or (f) personality disorder with or without comorbid substance abuse at the time of the genital self-injury. In the largest case series published on autocastration, Springer reported that he was able to document 37 cases in the English- and German-language literature between 1901 and 1981 (Springer, 1981), one of which was evaluated by him. Over half were attributed by the authors of the collected case reports to transvestism or transsexualism. The term transsexualism did not come into common usage until the 1960s, long after many of the early cases were reported; therefore, a clear diagnostic distinction cannot be made. When genital mutilation without the intent to remove the genitals is separated from those who engage in autocastration and autopenectomy, the primary diagnoses for those who intend to remove their genitals are further reduced to (a) GID (transsexualism), (b) bipolar mania, (c) schizoaffective disorder, (d) schizophrenia (with psychosis at the time of the act in the last three diagnoses but not in the first diagnosis) and comorbid psychotic disorder and GID with or without concomitant substance use disorder (Cole, O'Boyle, Emory, & Meyer, 1997; Novak-Grubic & Tavcar, 2002), or, rarely, (e) paraphilia other than transvestism (e.g., sexual masochism, Springer, 1981, chapter 7, p. 12). Autocastration has also been reported to occur just before a "first break" psychotic episode (Myers & Nguyen, 2001).

As with other types of self harm, it is important to understand the intent of genital self-harm for a given patient who engages in this behavior (Walsh & Rosen, 1988, p. vii-ix). Persons with GID often describe being repulsed by the presence of their genitalia and wish to have them removed as part of their overall transition from male to female. They may also discuss a desire to reduce testosterone by elimination of the main organs producing this "offending" circulating hormone. In this sense, patients with GID may engage in fantasized actual autocastration as a type of "surgical self-treatment" (SST), especially if they do not have access to appropriate medical care, e.g., cross-sex hormonal treatment and/or sex reassignment surgery (SRS). The term "genital mutilation," often referred to in the literature (Catalano, Morejon, Alberts, & Catalano, 1996; Martin & Gattaz, 1991; McGuire & Ahmed, 1998; Novello & Primavera, 1990), would therefore not be accurate for patients who engage in SST with the conscious, reasoned, intention to reduce testosterone levels in the absence of evidence of active psychosis when other less invasive alternatives are unavailable. Genital mutilation would appropriately refer to the infliction of pain or damage to one's genitalia for purposes other than such self-treatment. Genital mutilation, distinct from SST, has been reported in persons with personality disorders (Sockalingam & Stergiopoulous, 2005), psychotic disorders (Agoub, 2000; Cooper & Swamy, 1994; Gossler, Vesely, & Friedrich, 2002) and paraphilias (Money, 1988; Springer, 1981). It is likewise inaccurate to describe SST as a suicide attempt as this is not the intent of those who autocastrate, even in the context of psychosis (Blacker & Wong, 1962). Irrespective of the lack of intent to end their lives, persons who engage in this behavior may inadvertently die due to severe blood loss and hemodynamic collapse. Most of the individuals who autocastrate do not appreciate the elasticity of the testicular arteries. These arteries can quickly retract into the peritoneum, making self-hemostasis of the wound nearly impossible.

Autocastration in prison settings is most often associated with a primary diagnosis of GID that is undiagnosed and untreated, with numerous examples of such behaviors occurring in corrections facilities in multiple countries (Blight, 2000; Brown, 2003, 2007; Conacher & Westwood, 1987; More, 1996). This author has firsthand knowledge of cases of SST or other genital harm in five separate corrections facilities in Idaho, Wisconsin, Massachusetts, and Virginia. The co-occurrence of gender dysphoria and psychotic disorders is also reported, and one condition does not "protect" against the other. Therefore, patients may have both schizophrenia or bipolar disorder and gender dysphoria symptoms or threshold diagnosis

GID. Gender dysphoria may be an uncommon symptom in patients with a primary psychotic disorder (Mayer & Kampfhammer, 1995). Analytic theories of the past have held that gender dysphoria may represent a type of psychosis in and of itself (Siomopoulos, 1974), or a form of symbolic suicide (Menninger, 1938), but these theories have generally not held sway in modern psychiatric theories on the nature of GID (Brown, 2001). Generally, when gender dysphoria is present in patients without GID but with a psychotic disorder, the intensity of the gender dysphoria and risk for genital amputation is increased while they are in a psychotic state, but not necessarily when they are in remission from their primary psychotic symptoms. Patients with comorbid diagnoses of GID and a psychotic disorder display gender dysphoric symptoms while they are in remission from psychotic symptoms. In either situation, SST (autocastration, autopenectomy, or both) is a high risk, potentially lethal, possibly preventable, outcome of failing to appropriately address these serious symptoms whether the patient has a psychotic disorder with or without a diagnosis of GID. The combination of the two diagnoses would appear to represent the highest risk for serious genital amputation(s) (Mellon, Barlow, Cook, & Clark, 1989) whether in a prison setting or elsewhere, although data to support this hypothesis are lacking.

METHODS

Over the past 11 years, the author has received correspondence from 18 incarcerated persons claiming to have symptoms of gender dysphoria and requesting assistance with obtaining access to transgender health care in the form of evaluation, medical care, or both. Eight had claimed to have engaged in SST; five others indicated they were seriously considering such action. Of this group, five provided consent to be evaluated by the author, three of whom had completed autocastration (two with autopenectomy as well). All of these inmates had engaged in serious genital self-harm after incarceration but not before; one had inserted a needle into the urethra as a teenager in the reported belief that this would somehow make the doctors remove her penis. The three cases of completed autocastration are summarized below with alterations in demographic information to protect their identities. All were natal males and will be referred to by their preferred (female) pronouns consistent with clinical convention (Brown, 1990). Detailed medical, administrative, and mental health records were available for each inmate.

RESULTS

The case summaries and outcomes are described below. The initials do not correspond to those of any of the patients' real names.

Case AA

AA is a 52-year old natal male incarcerated in a western state for about 8 years. Prior to incarceration, she had been alcohol dependent and had engaged in a number of nonviolent crimes. She had reportedly suffered from gender dysphoric symptoms for years prior to this incarceration and requested an evaluation and treatment for gender identity disorder shortly after she was imprisoned. She had engaged in cross-dressing and had self-administered illicitly obtained cross-sex hormones intermittently prior to imprisonment. At the time of the index incarceration, there was no directive or guidance in this state to assist the Department of Corrections (DOC) health care staff in how to address potential GID in inmates. She was therefore denied access to both an evaluation and treatment by the warden of the institution. Upon receipt of this written denial, she gave verbal and written warnings to prison officials that she would autocastrate if she did not get evaluated for GID by an experienced mental health care provider. Prison officials documented that they viewed this as manipulative behavior for an unspecified secondary gain and continued to deny her access to an evaluation. When it became clear to the inmate that she would not be provided access to transgender health care, she cut off her testicles with a razor blade and flushed them down the commode. She was admitted to a local hospital and received numerous transfusions and surgical

interventions. She recovered and was returned to prison. Shortly thereafter, she informed DOC officials that if she did not receive an evaluation and treatment for GID symptoms, she would also autopenectomize in one year's time. At the end of one year, no assessment or treatments were forthcoming, and she amputated her penis and flushed it down the commode, necessitating another acute inpatient hospitalization and multiple blood transfusions. Legal intervention resulted in her transfer to another state for evaluation and treatment (which included cross-sex hormones) and a legal settlement with the DOC that, in part, established a new directive for the management of inmates in that state who claim to have GID. The cash settlement she was awarded was and is still the largest ever awarded to a prisoner in that state. Following SST, her symptoms decreased, and she did not regret "cutting off my stuff." She was later released after the completion of her sentence, but continued to live a marginalized life as a homeless person, unable to secure employment as a woman.

Case AB

AB is a 33-year old Caucasian natal male inmate incarcerated for a violent crime in a western state for at least 20 years to life with the possibility of parole at some time in the future. She reported verbal abuse and neglect by her mother and a series of abusive stepfathers while she was growing up. She was a veteran of the U.S. Army (2½ years) and was discharged prematurely "under honorable conditions" due to illicit drug use. She had a long history of mental illness with diagnoses to include paranoid schizophrenia, obsessive-compulsive disorder, bipolar disorder, and schizoaffective disorder recorded in her medical files, along with substance abuse. After incarceration, she initiated numerous written requests for an evaluation of her gender dysphoric symptoms. She described herself as "feeling like a hermaphrodite," and it was clear that she had little knowledge of the language of transsexualism or GID initially, but that she was expressing gender dysphoria and desire for cross-sex hormonal treatment. This was recorded by her in at least 75 written correspondences to the prison staff. She was denied access to an evaluation for GID but was treated for comorbid conditions with variable results, which included resolution of psychotic symptoms which were flagrant during the first months of her incarceration. She went on frequent hunger strikes to protest her treatment in prison, sometimes necessitating force-feeding. Her gender dysphoria persisted for years in spite other conditions being in remission, and she continued to request evaluation for GID. She changed her name to a female name while in prison. After at least two years of trying to obtain an assessment, she planned and followed through on autocastration. She flushed the testicles down the commode and was treated for significant blood loss at a local hospital. Detailed records by numerous observers in two institutions and in the ambulance did not detect any evidence of a thought or mood disorder before, during, or after this SST. No psychotic behavior was observed. Likewise, there was no evidence of substance use or intoxication that had occurred recently or during the autocastration. She was returned to prison, placed in solitary confinement on "suicide watch" but did not receive any assessment for GID. No alternative diagnostic theory was documented by DOC health care providers. She was offered intramuscular testosterone, which she refused to consider, pointing out that the purpose of autocastration was to eliminate testosterone. Nine months later, again in a clear mental state according to records, she amputated half of her penis and flushed it down the commode, preserving the other half as she believed it would be needed for SRS in the future. Over a year after this second genital self-surgery, she had yet to be evaluated for GID; she expressed no regrets whatsoever regarding her SST's and indicated that the severity of her gender dysphoria had abated somewhat. She is currently receiving no treatments for GID and litigation over this issue is ongoing. She also continues to go on intermittent, lengthy hunger strikes in protest.

Case AC

AC is a 26-year old Caucasian natal male incarcerated in a western state for property crimes and a subsequent brief escape from prison. She reported prolonged sexual abuse at the hands

of an adult male family friend before and after the onset of puberty. She engaged in repeated criminal activities, heavy drug abuse, and sexual offenses against minors when she was a teenager. She stated she used illicit hormones prior to incarceration and lived as a woman with a heterosexual male for nearly a year, although some of these statements are not verifiable. Diagnoses before incarceration at age 20 were limited to conduct disorder, antisocial personality disorder, substance abuse, and attention deficit-hyperactivity disorder. There was no history of a mood or thought disorder. The inmate petitioned the DOC for an evaluation of her long-standing gender dysphoria following the applicable DOC directive and was repeatedly denied access to a specialist in transgender health care. She accepted a transfer to a maximum security facility (even though her crimes did not warrant this placement) in order to obtain access to an evaluation and the potential for cross-sex hormonal treatment. She legally changed her name in prison, grew her hair and nails long, modified her prison garb to a more unisex appearance, and persistently presented herself as having symptoms consistent with GID. When it became clear to her that the DOC mental health treatment team was denying her access to transgender health care, absent an appeals process, she used a razor blade to remove both of her testicles and flushed them down the commode. Numerous chart notes from multiple health care providers in two institutions as well as ambulance personnel revealed no evidence of psychosis or intoxication before, during, or after self-surgical treatment. She provided a written, contemporaneous explanation of her actions: "I cut my genituls off do [sic] to the fact that I am a transgenderd [sic] individual and I could stand the sight of them no more. This is not a suicide attempt. This is simply a way for me to remmady [sic] my problem."

She was treated for hypovolemia and anemia at a local hospital and then returned to the prison. There was no change in the treatment plan, and no apparent consideration was given to the diagnosis of GID according to the records. Nearly two years after the surgical self-treatment, the inmate is pleased with the changes that have occurred in her body and psyche and she does not regret SST. She has been offered intramuscular testosterone by DOC physicians to address the osteoporosis inherent in the lack of circulating sex steroid hormones. The inmate has refused this intervention noting that the reason she engaged in SST was to reduce her testosterone levels. Recently, as a result of litigation, she has been started on a cross-sex hormonal regimen and is slated for early release on parole.

DISCUSSION

Autocastration and autopenectomy in natal males are complex behaviors with several potential underlying motivations (Menninger, 1938; Nakaya, 1996; Springer, 1981). Catalano et al. (2002), drawing upon the prior work of Blacker and Wong (1963), Greilsheimer and Groves (1979), and Martin and Gattaz (1991), listed 10 risk factors for "genital self mutilation": psychosis, alcohol intoxication, homosexual or transsexual feelings, guilt feelings for sexual offenses (real or imagined), separation or failure experiences, lack of responsiveness by health care providers to their requests for surgical castration, and a past history of genital self-mutilation. These characteristics were described in persons living in the community, but clearly there is overlap with this case series of incarcerated persons with GID. The main difference applicable to incarcerated persons with GID is that these patients frequently do not have access to psychiatric evaluations by those with experience in the assessment of persons with GID, let alone cross-sex hormonal treatment or sex reassignment surgery (Brown, 2003, 2007). With no other viable options, severe gender dysphoria in prisons that do not provide transgender health care may lead to desperate measures of self-treatment through permanent removal of the testes and/or penis in the absence of comorbid psychosis or substance use disorders. Abrupt cessation of estrogen treatment upon incarceration, not infrequently reported by inmates, can also lead to emotional instability, a reoccurrence of severe gender dysphoria, hopelessness, and the potential for genital harm and/or SST. The case reports described above indicate that SST is generally not spontaneous and is preceded by substantial efforts, both verbal and written,

at obtaining psychiatric and medical care for gender dysphoria. Without formal evaluation by experienced mental health clinicians, an individualized treatment plan following the World Professional Association for Transgender Health Standards of Care cannot be crafted or implemented. Even in the relatively Spartan and supposedly secure environment of a prison, motivated gender dysphoric inmates are still able to remove their testicles, penis, or both when they lose hope of access to transgender health care. This leaves them at risk for potential unintentional fatal hemorrhage. Although reliable data do not exist, it is likely that the probability of SST by incarcerated persons with GID substantially exceeds that seen in GID populations who have access to transgender health care. In this author's nearly three decades of experience evaluating hundreds of persons with GID, only one case of completed (unilateral) autocastration was encountered from a population of nonincarcerated gender dysphoric persons. This patient had a primary diagnosis of schizophrenia with secondary gender dysphoric symptoms while psychotic. He used a pneumatic nail gun to "shoot" one of his testicles and then reported to an emergency room with his testicle and scrotum nailed to a wooden chair. When his psychosis was controlled, he did not express a wish to harm his genitals.

As noted in some of the references included in the introduction, SST of gender dysphoria outside of prison settings has been reported, as access to transgender health care is by no means universal, available, or affordable in many countries, notably the United States. However, resourceful gender dysphoric persons are often able to obtain cross-sex hormones by illicit or legal means, which may obviate the need for more desperate attempts at SST (Brown, 2003). Persons with GID in prison settings generally do not have the ability to seek other alternatives for relief of severe gender dysphoria if they are denied access to treatment. The length of the inmate's sentence may also be a correlate of engaging in SST but there are not enough data to test this hypothesis.

The cases illustrated above should alert both prison officials and health care providers in prison settings to the possibility of life-threatening SST in their inmate populations with alleged or diagnosed severe gender dysphoria. In all three of these cases, the inmates communicated their feelings of gender dysphoria and their requests for psychiatric and medical evaluation for GID. In all cases, access to appropriate evaluation and treatment was denied by prison officials prior to any of the inmates engaging in SST or genital harm. Some prison systems now have directives in place that are supposed to provide for an evaluation of inmates who claim to be transgendered individuals (e.g., California Department of Corrections and Rehabilitation, 2007; Idaho Department of Corrections, 2003; Wisconsin Department of Corrections, 2002), with the possibility of obtaining consultative services from health care providers experienced in evaluation and management of GID. Such policies are by no means universal, nor are they necessarily implemented when they do exist. Many states' Departments of Correction provide no guidance on this issue as of late 2007 (e.g., Maine, Mississippi, and Rhode Island); some actually prohibit the provision of evaluation for gender identity disorder other than confirming a preexisting diagnosis prior to incarceration (e.g., Washington State Department of Corrections, 2006).

In prison settings where access to cross-sex hormonal treatment is a reasonable expectation as part of transgender health care for appropriately diagnosed inmates, SST is not reported (Denise Taylor, MD, & Lori Kohler, MD, personal communications, December 2007), which further supports the theory that the relevant issue underlying SST is lack of access to transgender health care and not incarceration itself. Departments of Correction that routinely block access to cross-sex hormonal treatments for GID have been subjected to protracted litigation and its attendant costs, as well as financing emergency room/ICU care for inmates who must be treated emergently when they engage in SST. Ironically, Departments of Correction will spend far more taxpayer dollars preventing access to transgender health care than they would if they provided appropriate, nonemergent care following the WPATH Standards of Care for the small number of incarcerated persons with GID.

A 1996 survey of 64 prison systems in North America, Australia, and Europe (Petersen,

Stephens, Dickey, & Lewis, 1996), the most recent published survey of its kind, revealed that only 20% of facilities had any formal policies addressing transgender health care and housing and another 20% had "informal" policies. In the United States, that number has risen in the last decade to at least 18 states, the Federal Bureau of Prisons, and the District of Columbia (2007 Freedom of Information responses from 23 states; 27 states did not respond to the request for information), with the majority of the directives effective after 2000. Some of these directives or policy letters are simply to clarify that no transgender health care will be provided without SRS having been completed prior to incarceration and that cross-sex hormones prescribed at the time of incarceration will be discontinued under all other circumstances (e.g., Florida Department of Corrections, 1995; Kansas Department of Corrections, 2003), or "maintained" at the same "transgender status" as the inmate was upon incarceration (Georgia Department of Corrections, 2001). In 2000, the Australian Institute of Criminology published a review of the Australian state policies on transgender inmates. The report concluded,

> Transgender inmates present a unique set of issues that, if not appropriately dealt with, could lead to a greatly increased incidence of assault and self-harm in that population. Failure to implement appropriate policies may also amount to a breach of antidiscrimination legislation and/or human rights obligations. (Blight, 2000)

In the United States, the point prevalence of incarcerated persons (excluding municipal jails) with GID may be between 2 and 400 per state, with the largest states (e.g., California, New York, Florida, and Texas) having the greatest number at any given time. Although precise figures are not known, a reasonable estimate is that there are between 500 and 750 inmates in custody in state facilities and possibly another 50 to 100 in federal facilities. It is estimated, for example, (based on court documents) that approximately 7 to 9 inmates in Massachusetts were known to have GID in 2005, approximately 5 in Idaho in 2007, and similar numbers in Wisconsin in 2007. California is estimated to have as many as 400 transgendered inmates (including small numbers of female-to-male transgender inmates) at any given time (L. Kohler, personal communication, 2006, 2007, 2008). Many inmates are not diagnosed, making any estimates less accurate. In any event, even at the highest end of the estimates provided, this is a relatively small population compared to the 2,396,002 inmates in custody in the United States in December, 2008 (Bureau of Justice Statistics, 2008). If one uses the lower end of these rough estimates, it is still likely that persons with GID are overrepresented in prison settings. While precise population estimates of GID in the United States do not exist, using the estimate of 1/11,000 male-to-female transsexuals derived from a Dutch study of prevalence (Ketteren, Gooren, & Megens, 1996), only about 218 natal male inmates with GID would be expected in the United States when the general population is approximately 300,000,000 (with an estimated 27, 272 persons with GID) and the prison population is 2.4 million, the vast majority of whom are male. The more liberal estimates of Olyslager and Conway (1:1000 to 1:2000 live births; 2007) would result in a five- to tenfold difference in this estimate. The inmate population with GID in California alone exceeds the expected number for the entire nation if persons with GID were not incarcerated at a higher rate than the estimates of their numbers in the U.S. population. Similar conclusions of a higher prevalence of GID in the incarcerated population compared to the "free" population have been reached in Scotland, where an estimated 1:12,400 men over the age of 15 have GID (Elkins, Olagundoye, & Rogers, 2001). Poverty, social and vocational marginalization, poor psychosocial functioning, rejection by family/friends/employers, and psychiatric comorbidities are all likely to contribute to this phenomenon.

CONCLUSION

Surgical self-treatments by incarcerated persons are dramatic, potentially lethal, but possibly preventable, sequelae of denial of access to transgender mental and medical health care

in the prison setting. Early reviews of cases in the community noted common characteristics in those who engaged in SST: impoverished childhood experiences, repudiation of male genitalia, relief of depression by genital mutilation, sexual identity confusion, submissive and/or masochistic relationships with women, and intense cross-gender identifications (Blacker & Wong, 1963). Clearly, some of these descriptors applied to some of the cases presented, but it appears that the salient characteristic common to all of these cases is denial of access to appropriate psychiatric evaluation and treatment in an institutional setting where few other options existed for severely gender dysphoric inmates. SST resulted in amelioration of some symptoms of gender dysphoria when cross-sex hormonal treatment was not provided, and those who engaged in this behavior did not regret this self-surgery at one or more years after the event. SST, in all cases reported herein, occurred in the absence of active psychosis or intoxication and was planned in advance, apparently associated with a loss of hope that more traditional transgender health care would be forthcoming. Given the lethal potential, as well as the costs of emergency care and attendant litigation, departments of correction that do not provide for evaluation and individualized treatment planning should consider reviewing their approaches to the evaluation and management of inmates who report symptoms of gender dysphoria. Evolving published standards of care for the psychiatric, medical, and surgical care of persons with GID (e.g., Levine et al., 1998; Meyer et al., 2001 should be more comprehensive in addressing the health care needs of persons with GID in institutional settings.

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EXHIBIT

Q

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN,

Plaintiff,

vs. Case No. 4:16-CV-01357-NCC

WILLIAM MCKINNEY, et al.

Defendants.

Confidential

Videotaped Deposition of

GEORGE BROWN, MD

Taken on behalf of the Plaintiff

Monday, October 23, 2017

Johnson City, TN

Job No: 132639
Reported by: Kristin E. Burke, LCR

world, even if some people don't like that, I'm very comfortable with the transition I've made, and I feel much, much better about myself."

BY MS. GORDON:

Q. I'm going to take a step back to talk about -- you laid out the current triatic therapy as most people in the professional community understand it: social role transition, hormone therapy, surgical interventions.

For any individual person, the menu, so to speak, of the treatment options that would be required to effectively treat their gender dysphoria has to be determined on an individualized basis, correct?

MR. ECKENRODE: Just going to object to the overbroad form of the question and the premise.

But go ahead.

THE WITNESS: I would answer that, basically, for any complex psychiatric or medical disorder that has a number of different treatments that it is definitely done on an individualized basis, also taking into consideration the time course of the condition.

BY MS. GORDON:

Q. So speaking specifically about gender

dysphoria, determining what is medically necessary for any given person who has been diagnosed with gender dysphoria is necessarily an individualized and case-by-case process, correct?

A. Yes.

Q. So with respect specifically to the current triatic therapy framework of social transition, hormone therapy, and surgical interventions, which, if any, of those things and in what combinations might be medically necessary for any individual person diagnosed with gender dysphoria is necessarily an individualized and a case-by-case process, correct?

MR. ECKENRODE: Same objection.

THE WITNESS: I'm sorry. I'm not following what the question is.

BY MS. GORDON:

Q. Basically, you laid out the current understanding or the current conception of triatic therapy, and it has at least three things in it. Well, "triatic" means three, so that makes sense. And the three things you laid out are social transition, hormone therapy, and surgical interventions.

So what I'm trying to get at is: How do you

combination of the two for people who are willing to engage in that is probably optimal.

But your question was as a substitute for it.

So, if somebody -- if somebody has progressed and they -- and they need to have social transition as part of their care, psychotherapy about that without them engaging in it would not be a substitute.

Q. And for someone for whom hormone therapy has been determined to be medically necessary to treat their gender dysphoria, psychotherapy is not a substitute in that situation for hormone therapy, correct?

A. Correct.

MR. LUEPKE: I object that the question is vague and confusing.

Subject to that, you may answer.

THE WITNESS: I answered, "Correct".

BY MS. GORDON:

Q. I believe you already answered.

And for someone for whom gender confirmation surgery or sex reassignment surgery has been determined medically necessary to treat their diagnosis of gender dysphoria, psychotherapy is not

a substitute for those kinds of surgical interventions, correct?

A. Right. So --

MR. LUEPKE: Same objection.

THE WITNESS: So given -- given the hypothetical that somebody has been determined to be medically necessary to have sex reassignment surgery, psychotherapy would not be a substitute.

BY MS. GORDON:

Q. Are psychotropic medications like antidepressants and antianxiety medications appropriate treatment for gender dysphoria?

MR. ECKENRODE: Object to the overbroad form.

You can answer.

THE WITNESS: Yeah. I would have to have the question a little bit different because I consider cross-sex hormones to be psychotropic medications also --

BY MS. GORDON:

Q. Okay.

A. -- based on how people's brains respond and minds respond.

So, given that, do you want to ask me the question in a different way?

patient I saw that was eligible was hormones, could get access to hormones but didn't want them for a relative contraindication.

Q. How about outside of the prison context? Have you had patients who couldn't take hormones for whatever reason, and how did you approach treating their gender dysphoria?

A. Yes, I have seen veterans who had a variety of cardiovascular issues, heavy smoking, who were at significant, elevated risk from estrogens who chose not to take hormones, but it's uncommon. I mean, most gender dysphoric people in the moderate to severe category, let me specify that, choose to take hormones in spite of risks to their health, so the relative contraindications.

And I have treated many people with relative contraindications far more than people who have chosen not to be on hormones who have moderate or severe gender dysphoria and choose not to be on hormones. So that's -- it's just an uncommon situation in any practice.

Q. Okay. As a general proposition, based on your experience and your expertise, for persons who can't take hormones for whatever reason and who are diagnosed with moderate or severe gender dysphoria,

is it fair to say that it is important to find other mechanisms for addressing the moderate to severe gender dysphoria in that -- in that setting?

A. Yes.

Q. And what those other treatments might look like, again, is going to depend on an individualized assessment of what would be effective to help treat the person's gender dysphoria in that context, correct?

A. Correct.

Q. And at least in the one case that you talked about in the prison context, what you recommended for that person who couldn't take hormones was a specific intervention in the form of a mas -- a specially-made mastectomy bra that would fall under the umbrella of social role transition.

Is that correct?

A. Technically, yes; although, really a hormone substitution, as well. So -- and it definitely fell within the medically necessary rubric in that case.

Q. Okay.

Have you seen anything in the records that you reviewed -- going back to Jessica Hicklin specifically, have you seen anything in the medical records or any of the records that you've reviewed

So -- but all of that is basically talking to the individual. So the vast majority of that information is gathered through a clinical interview.

BY MS. GORDON:

Q. So it's important, then, to speak to the patient, correct?

A. Right, which is why I'm -- I'm not able to answer some of your questions because I have not had the opportunity to speak to this patient.

Q. Okay. If you turn to Page 25, the last paragraph on that page starts with a sentence that says: It is important for mental health professionals to recognize that decisions about hormones are first and foremost the clients' decisions as are all decisions regarding health care.

Can you explain the significance of this sentence?

A. Yeah. I think that's a sentence that's subject to misinterpretation.

So, the -- the sentence, taking the last part of it first, it's basically saying, you know, competent people should be made -- should be involved in all decisions regarding their health

A. Correct.
Q. Okay. So I want to switch gears a little bit to talk specifically about this case, Jessica Hicklin's case.
You are aware that this case is brought by a transgender woman by the name of Jessica Hicklin, correct?
A. Correct.
Q. Have you met Jessica Hicklin?
A. I have not.
Q. Did you ask to meet Jessica Hicklin?
A. I'm sure in the course of discussing the case over the number of months, the question came up as to whether I would be afforded that opportunity and whether it was considered necessary for me to meet her.
Q. So you say the question came up. Did you raise the question of the possibility of meeting her?
A. I'm sure I did because I always ask in the beginning of a case whether I have a lot of travel involved or less travel involved, what the questions are, whether I feel that it's absolutely critical for me to have a face-to-face interview.
And, again, every case is different. Some

that. And I have no reason to believe that she doesn't, but I've never interviewed her. So, if you ask me: Does she have gender dysphoria as a diagnosis? I can't say yes to that.

So with respect to this question, they didn't say -- they didn't say, Well, we don't need you to make a diagnosis. Everybody is agreeing that there's a diagnosis of gender dysphoria, so that's not -- that's not at -- at odds here.

And I said, Okay. So what -- so is it a matter of reviewing records and rendering an opinion about what is reviewed in the records, then I don't necessarily have to interview the person for that. So whether I interview the person or not is based on what questions I am being asked to answer.

Q. Okay. So just to be -- just to be clear, have you ever talked to Jessica Hicklin on the phone?

A. No.

Q. Have you ever exchanged any letters or mail with her?

A. I have had no contact with Jessica Hicklin of any type.

Q. Okay. So what is it that you agreed to

Plaintiff has -- has been administered appropriate cross-sex hormone therapy for a period of time to determine the impact of the therapy on Plaintiff's body.

I've actually addressed this in much greater detail in my report, and I stand by what's in my report.

Q. Okay.

A. This is dif -- this is different in terms of timing, so I'm not going to say that I agree with the exact wording in that sentence. And then I'm going to defer to my re -- actual report for my statements on that.

Q. Okay. So it is not your opinion that Jessica Hicklin -- let me -- let me scratch that.

Is it not your opinion that hair removal therapy should be considered for Jessica Hicklin only after she has been administered appropriate cross-sex hormone therapy for a period of time to determine the impact of therapy on her body?

A. Right. I disagree with that.

The reason being that hair removal should be considered -- can be considered -- can be considered at various stages in a person's transition, and to say only after, I would disagree

the past, as well. One that comes to mind is Sun -- Sunstrum case in Wisconsin.

There are situations where somebody asks me to do a case and, for whatever reason, I can't or I'm not willing to do a case, and it's not uncommon for me to refer the case to her and vice versa.

Q. Have you collaborated with Dr. Ettner on research projects?

A. Oh, yes. Thank you for pointing that out.

We also have published papers together and have done presentations at WPATH meetings, particularly on the issues of transgender health in institutional settings, most recently at the last -- the last WPATH meeting in Amsterdam, and that would have been in June of 2016.

Q. Are you challenging any of Dr. Ettner's opinions in this case related to what is medically necessary specifically to treat Jessica Hicklin's gender dysphoria?

A. Well, I can't challenge her opinions because I have not interviewed Ms. Hicklin. So I can't comment on whether what Dr. Ettner is saying is medically necessary is -- is or is not, on the basis of my lack of the same level of understanding of -- of Ms. Hicklin as -- as Dr. Ettner has.

Q. Because you're aware that Dr. Ettner has actually conducted an individualized gender dysphoria assessment of Jessica, correct?
A. Over three hours long, from what I recall.
Q. Among the materials cited in your report and brought to today's deposition is a book edited by Dr. Ettner, correct?
A. Correct.
Q. She's -- her -- hers is the -- I don't know enough about how these things work. Hers is the first name listed among the authors. Does that signify anything as far as her level of contributions to the book? Can she be called the head author? What does that mean?
A. Sometimes they're alphabetical. Sometimes they're decided upon --
Q. This one's not.
A. It's not in this case, because Coleman is listed third.
I don't really know how Drs. Ettner, Coleman and Monstrey -- all of whom I know well, how they determined who would be listed first, second and third, but they're all listed as -- as editors.
Q. So continuing in the Relevant Summary of the Case section on Page 4, the second full paragraph on

that -- on that page, the last sentence says: "She", referring to Jessica Hicklin, "has had symptoms that are generally considered as a severe manifestation of gender dysphoria, specifically recurring" -- sorry -- "specifically recurrent suicidal ideation and intrusive thoughts of autocastration."

And then I think you cite two of the papers that we have discussed today, correct?

A. Correct.

Q. So, as we've discussed, you have studied this topic fairly extensively, correct?

A. Correct.

Q. The next sentence says: "On 4/15, Jessica Hicklin filed a grievance for electrolysis, cross-sex hormones, and access to items available in the female canteen for female inmates of MDOC. These requests were denied, and the parties ultimately responsible for the denials are unclear to me based on the records available."

Well, let me just ask you: What do you -- what do you mean by that, by -- by the sentence where it says: "These requests were denied, and the parties ultimately responsible for the denials are unclear to me based on the records available"?

The consequences of denying medically care -- scratch that.

The consequences of denying medically necessary care can be very serious and put the patient at serious risk of harm, correct?

MR. ECKENRODE: Same objection. Overbroad. Lacks foundation.

You can answer.

THE WITNESS: Again, we're talking generically?

BY MS. GORDON:

Q. Yes.

A. Yes.

Q. And based on your research, this is particularly the case for someone who is incarcerated and who has struggled with suicidal thoughts and thoughts of autocastration, correct?

MR. ECKENRODE: Same objection.

THE WITNESS: Yes. That's what I have written on, as well.

BY MS. GORDON:

Q. For someone with severe gender dysphoria who cannot take hormones for whatever reason, is it fair to say that other forms of gender dysphoria treatment, such as social role transition or some

other mechanism of gender dysphoria treatment, become even more important for helping that person consolidate their gender identity and alleviate their gender dysphoria symptoms?

MR. ECKENRODE: Same objection.

MR. LUEPKE: Object. Beyond the scope of the pleadings.

Subject to that, you can try and answer.

THE WITNESS: I didn't hear that. Did I need to?

MR. ECKENRODE: No.

THE WITNESS: Okay. Yes, in the -- in the unusual situation where somebody with moderate to severe gender dysphoria is unable to take cross-sex hormones for whatever reason, certainly -- well, even if they are able to take them, take cross-sex hormones, there are usually other elements of their treatment plan, but those other elements would assume a relatively higher level of importance if you're not able to employ cross-sex hormone therapy, which is a pretty potent treatment.

BY MS. GORDON:

Q. Dr. Brown, you shared your opinion regarding Corizon's conduct with respect to Ms. Hicklin's gender dysphoria with your stated caveats and

EXHIBIT

R

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

No. 1:00-cv-12455-MLW

MICHELLE KOSILEK,
Plaintiff

vs.

THE MASSACHUSETTS DEPARTMENT OF CORRECTION, et al,
Defendants

****

For Trial Before:
Chief Judge Mark L. Wolf

Excerpt Transcript: Testimony of George R. Brown, M.D.

United States District Court
District of Massachusetts (Boston.)
One Courthouse Way
Boston, Massachusetts 02210
May 30th and 31st, 2006

****

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Official Court Reporter
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PROCEEDINGS

(May 30, 2006, Dr. Brown.)

THE COURT: And, Ms. Cohen, would you like to call the first witness.

MS. COHEN: Yes. Mr. Sulman is just fetching him from the corridor, your Honor.

THE COURT: Okay.

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GEORGE R. BROWN, M.D.

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(GEORGE RICHARD BROWN, sworn.)

THE COURT: You may proceed.

MS. COHEN: Thank you.

DIRECT EXAMINATION BY MS. COHEN:

Q. Good morning, Dr. Brown.

A. Good morning.

Q. Would you state your full name, please.

A. George Richard Brown, M.D.

Q. Dr. Brown, do you have in front of you what has been previously marked for identification as the Plaintiff's CV, which is a copy of your evaluation with your Curriculum Vitae attached?

A. (Looks.) Yes, ma'am, I do.

Q. What was the date on which you prepared your Curriculum Vitae? It says April 1st, 2006. Is that accurate?

A. That's accurate that you have that copy and I have a copy, but it's not accurate currently.

Q. What changes have there been to your Curriculum Vitae since it was prepared on April 1st, 2006?

THE COURT: I'm sorry. What exhibit is this, "BB"?

MS. COHEN: It's "BB", your Honor, which is a copy of Dr. Brown's report, dated October 12th, 2005, with an appended copy of his Curriculum Vitae dated April 1st, 2006.

THE COURT: And I had understood that this is one of the proposed exhibits as to which the defendant had an objection?

MS. COHEN: Yes. I would offer it now, your Honor, as the -- unless the defendants' objection is ongoing.

MR. McFARLAND: It is ongoing.

THE COURT: Well, let's see. This is Dr. Brown's October 12, 2005 report and his attached CV. Is there an objection to his CV going into evidence?

component of the treatment plan. I mean, the treatment plan for this, as we've talked about, is not just a treatment here and there, it's a comprehensive progressive treatment plan. So although there were delays that were apparent to me in the records that I reviewed, she has received access to some of the treatments that have been recommended.

THE COURT: And are the treatments she's now receiving, the psychotherapy and the hormones primarily, sufficient to eliminate the significant risk of serious harm that you described, in your opinion?

THE WITNESS: Absolutely not.

THE COURT: And is that why you've described the Sex Reassignment Surgery as medically necessary?

THE WITNESS: Absolutely. If I can walk away from these proceedings with one point being clear in people's minds, it's that.

THE COURT: And how would you state that point in your own words?

THE WITNESS: My own words are that Sex Reassignment Surgery for this patient at this time in her life is medically-necessary treatment without which the degree of likelihood of her suffering serious medical consequences up to and including suicide are exceedingly high.

THE COURT: And then you touched on something that I was going to ask you about. Is there anything, in your opinion, other than Sex Reassignment Surgery that could reduce the significant or substantial risk of serious harm that you've included, including, but not limited to, the use of antidepressants like Prozac?

THE WITNESS: There are no proven effective treatments for this level of the disorder in this inmate, in this type of patient, at this time that are proven to be effective in preventing what I'm describing. So the answer would be, no, there are no other effective treatment in the literature and in my personal experience. I would use them if they were there, but they're not there.

THE COURT: Why would you use them if they were there?

THE WITNESS: Because SRS is a very expensive procedure, it's a painful procedure, and it's irreversible. And anything that I can provide, as a clinician, as a psychotherapist, as a prescriber, I would provide it. I'm not a surgeon. I obviously stand to gain nothing from people having surgery. I don't do surgery. I do all the things but surgery. And if I can bring those things to bear for the benefit of a patient with this level of severity of a condition that would be

otherwise effective, I would do it. And if others have data that show that doing Psychotherapy X or Group Therapy Y is effective in somebody with severe GID, I would seriously consider that, but it doesn't exist.

THE COURT: And why wouldn't Prozac or some other antidepressant or, indeed, some other medication sufficiently diminish the distress, in your opinion, to be adequate, if not ideal, but adequate in the sense of reducing the condition so there's not that substantial risk of self-harm, including suicide?

THE WITNESS: Well, antidepressants like Prozac, as the example, treat symptoms in some patients with a diagnosis of major depressive disorder, which she doesn't have and didn't have in 2001, and, in fact, treatments with antidepressants for gender disorder patients have been shown to be very ineffective. They may slightly relieve some of the symptoms of depression, but in no way do they treat the underlying cause of the disorder, which is GID, not depression.

THE COURT: But even if they didn't treat the underlying cause, does medication have the potential, in your opinion, to eliminate the substantial risk of serious harm?

THE WITNESS: No, it doesn't have the potential at all.

THE COURT: Why?

THE WITNESS: Because the medications don't work for the diagnosis. And, in fact, antidepressants are only effective in about 60 to 70 percent of patients who have depression as the proper diagnosis. So you're still left with 30 to 35 percent of severe depressions that don't respond to antidepressants at all and they may have to increase the type of treatment and move beyond it. Again, the concept of mild, moderate or severe. And then you're looking at things like shock therapy or electric convulsion therapy, implantable devices on the Vagus nerve, which is a surgical procedure, a variety of things for that other 30 percent of severe depressives who don't respond to antidepressants. So, no, I don't think antidepressants would at all work in this situation.

THE COURT: As I recall, as I wrote four years ago, I think on Page 168 of what you have: "The 'Standards of Care' indicate that hormone therapy can provide significant comfort to patients who are unable to undergo surgery and may obviate the need for surgery." As a general proposition, putting aside the particular patient, do you agree with that?

THE WITNESS: Yeah, and that's where the concept of "moderate" comes in. I mean, "mild" and

EXHIBIT S

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No.
	)	4:16-CV-01357-NCC
	)	
ANNE PRECYNTHE, et al. ,	)	
	)	
Defendants.	)	

DEPOSITION OF ELIZABETH ATTERBERRY, PSY.D.
TAKEN ON BEHALF OF THE PLAINTIFF
NOVEMBER 15th, 2017

JOB NO. 133533

Q. Do you have an understanding of what social transition is -- strike that.

Do you have an understanding of what it means -- strike that.

What does a change in gender expression and role mean in the context of treatment for gender dysphoria?

A. One more time. What does --

Q. What does a change in gender expression and role mean in the context of treatment of gender dysphoria?

A. Broadly, living to learn -- or live as the gender that you identify with.

Q. And what does that entail?

A. A variety of things.

Q. What might it entail?

A. Physical appearance.

Q. What aspects of physical appearance?

A. It depends on what that individual identifies as -- let's say someone transitioning to a woman, what's important to them to identify or express femininity may be different for other patients.

Q. Might a patient who is transitioning to being female, might that patient feel like her hair

is an important expression for her?

MR. ECKENRODE: Object to the overbroad form. You can answer.

Q. (By Ms. Roberg-Perez) In terms of changing gender expression, when talking about a transgender woman, might that individual feel like part of an expression that's important to her is her hair?

MR. ECKENRODE: Same objection.

A. It depends on the patient.

Q. (By Ms. Roberg-Perez) Are you aware of patients who feel that way?

A. Yes.

Q. Might a change in gender expression involve hair removal through electrolysis, laser treatment or waxing?

MR. ECKENRODE: Same objection.

A. "Might" was your question?

Q. (By Ms. Roberg-Perez) Yes.

A. Say it again, please.

Q. Might a change in gender expression be expressed through hair removal through electrolysis, laser treatment, or waxing?

A. Yes.

Q. And you'd agree it's possible for transgendered woman who are incarcerated to undergo

A. No.
Q. Heino Meyer-Bahlburg?
A. No.
Q. Blaine Paxton?
A. No.
Q. Katherine Rachlin?
A. No.
Q. Bean Robinson?
A. No.
Q. Loren Schechter?
A. No.
Q. Vin Tanpricha?
A. No.
Q. Anne Vitale?
A. No.
Q. Okay. Are you aware that you've been identified as an expert in this case?
MR. ECKENRODE: Nonretained exert.
Q. (By Ms. Roberg-Perez) Are you aware that you've been identified as a nonretained expert in this case?
A. Yes.
Q. And we'll get to your opinion in a bit. So you've already testified that you have never met Ms. Hicklin; correct?

A. Correct.
Q. You've never spoken to her, have you?
A. No.
Q. Do you know that -- do you know whether she's provided testimony in this case?
A. Yes.
Q. Have you reviewed her testimony?
A. Yes.
Q. So you're aware that she's testified that she has suicidal ideations?
A. Yes.
Q. And that means that she imagines committing suicide?
MR. LEVY: I object to the question. It's outside of the scope of knowledge of this witness.
But subject to that, you can answer?
MR. ECKENRODE: Join. It's overbroad.
You can answer.
Q. (By Ms. Roberg-Perez) Dr. Atterberry, you just testified that you reviewed Ms. Hicklin's deposition; correct?
A. Yes.
Q. And that you're aware that she's testified that she has suicidal ideations?
A. Yes.

care set forth by the APA"; Correct?

A. Yes.

Q. And the WPATH Standards?

A. Yes.

Q. Okay have you reviewed the APA standards of care for people with gender dysphoria?

A. Yes.

Q. When is the last time you reviewed those standards?

A. I cannot recall.

Q. And we spoke earlier about the WPATH Standards. Before today, do you remember when you last reviewed the WPATH standards?

A. I do not.

Q. Okay. Of Corizon personnel, who has evaluated Ms. Hicklin for gender dysphoria specifically?

A. Dr. Thrupe and Dr. Stephens.

Q. Anyone else?

A. Evaluated, I would say, just those two.

Q. And would it be correct, then, that -- so you make a distinction between evaluated and something else. What's the something else?

A. In treating, working with, talking with Ms. Hicklin.

letter; correct?

A. Yes.

Q. Okay. It's correct that you've never conducted a gender dysphoria evaluation of Ms. Hicklin; correct?

A. That is correct.

Q. And you testified earlier that the two Corizon employees who have done that are Dr. Thrupe and Dr. Stephens; correct?

A. Correct.

MS. ROBERG-PEREZ: Can we take a five-minute break, and then we're going to do some cleanup and be close to being done.

MR. ECKENRODE: Okay.

(A recess was taken.)

Q. (By Ms. Roberg-Perez) I'm going to ask the reporter to hand you what was marked as Exhibit 52.

MS. ROBERG-PEREZ: Counsel, these are notes that Mr. Eckenrode brought in to the deposition just arranged in date order.

(Deposition Exhibit No. 52 was marked for identification.)

Q. (By Ms. Roberg-Perez) Okay. Dr. Atterberry, for the record, the reporter has handed you six stapled pages marked Exhibit 52. Do

Q. And that went to Jamie Crump at DOC?
A. Yes.
Q. And why did that go to Jamie Crump?
A. At the time, that individual was the chair of the Potosi Correctional Center Transgender Committee.
Q. Okay. And you also testified about this earlier, about how the GDCSG makes recommendations to the on-site transgender committees?
A. That's correct.
Q. Okay. Directing your attention to the next page, there is handwritten notes from January 25th, 2017. Do you see that?
A. I do.
Q. Are these your notes?
A. They are.
Q. And there's reference to -- through treatment team discussion, how facial hair is a big issue. And that -- does that refer to Ms. Hicklin having a big issue about facial hair?
A. Yes.
Q. And the next sentence is how to deal with appearance; correct?
A. Correct.
Q. And what does the committee -- what was

the discussion in the committee about Ms. Hicklin having a big issue with facial hair and how to deal with her appearance?

A. My recollection is that Ms. Polk was presenting that these were ongoing difficulties that Ms. Hicklin is experiencing.

Q. And so this is in January of 2017, almost two years Ms. Hicklin was diagnosed with gender dysphoria; right?

A. Yes.

Q. And the GDCSG has recommended hormone therapy, but it has not been -- not been provided as of this date; correct?

A. Correct.

Q. And so was there -- there's a recommendation -- there's a referral to a treatment plan down here. "Treatment plan approved." Do you see that? On this page. Diagnosis --

A. Yes. Uh-huh.

Q. What treatment plan was approved? Because It's not hormones; correct?

A. Correct.

Q. What treatment plan?

A. It's an individualized treatment plan that the QMHP at the time had worked on with Ms. Hicklin.

EXHIBIT

T

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No.
	)	4:16-CV-01357-NCC
	)	
ANNE PRECYTHE, et al. ,	)	
	)	
Defendants.	)	

Jefferson City, MO

DEPOSITION OF ELIZABETH ATTERBERRY, PSY.D.

TAKEN ON BEHALF OF THE PLAINTIFF

February 6, 2018

Reported by: LISA BALLALATAK

Job No. 135754

Q. So MDOC can at any time it chooses allow Ms. Hicklin to purchase canteen items that she would like to make her feel more comfortable; correct?

A. It is at their discretion.

Q. But Corizon could recommend it, couldn't it?

A. I suppose that they could.

Q. Are you aware of inmates being denied canteen items because of the gender population with which they're housed? In other words, if someone is housed with male inmates, are you aware of being denied canteen items because the canteen items are specifically female?

A. I am aware that certain items are sold at the female institutions and certain items are sold at the male institutions. I'm not aware of a specific denial of any canteen items.

Q. Are you aware that Dr. Stephens recommended canteen items for Ms. Hicklin -- or access to female canteen items?

A. At some point in time, yes, I believe that was a recommendation.

Q. And so given that, why has Corizon not recommended canteen items for Ms. Hicklin?

A. As part of the GDCSG at this time -- and

for some time now, our main emphasis and desire and recommendation is for Ms. Hicklin to receive hormone replacement therapy. Once she receives that, our assessments will continue, as they always have, and see -- there may be other things that we recommend or not.

Q. So is it Corizon's view that Ms. Hicklin should receive the hormone treatment, and then it should wait for canteen -- to consider canteen items until she gets that hormone treatment?

A. No.

Q. So then why has Corizon not recommended canteen items?

A. We would like her to receive HRT. That's what we really want for this patient, and we believe that that is a start. The process of transitioning is lengthy, and we would continue to assess what her needs are. And at this time, we can't really foresee what all the future will bring, once she does receive the treatment, and that, I couldn't speak to, but I know that is our belief at this time, is that our assessment would continue. It's ongoing.

Q. Does Corizon not see any benefit to Ms. Hicklin of her receiving canteen items, even in

the absence of hormone treatment?

A. Per what the patient is indicating, that would be desirable, but that is right now at the discretion of the department.

Q. Doesn't Corizon think, though, that in the absence of hormone treatment -- especially in the absence of hormone treatment, canteen items could be beneficial for Ms. Hicklin?

A. There are other things that we believe would be more beneficial.

Q. I understand. And one of those things is hormone treatment; correct?

A. Correct.

Q. But in the absence of hormone treatment, because I understand Corizon has recommended hormone treatment, and MDOC has thus far refused.

A. Correct.

Q. But in the absence of hormone treatment, given the situation as it exists, doesn't Corizon believe that access to canteen items could be helpful to Ms. Hicklin?

A. Per what Ms. Hicklin indicates, yes, we believe they would be desirable. We also believe in the absence of the HRT, that psychotropic medication for the treatment -- the direct treatment of the

symptoms would be more beneficial.

Q. More beneficial than what?

A. Than the absence of them. It's double absence, I guess, is what I'm trying to communicate.

Q. Understood.

Have you heard the phrase "medical lay-in"?

A. Yes, I have.

Q. What is it?

A. It's a departmental term, and it's used for when the physician indicates a situation or a condition that requires some special consideration.

Q. Medical lay-in comes from a physician?

A. Yes.

Q. What's the process for putting in a medical lay-in for an inmate?

A. Once the physician makes a determination, there's -- somewhere within the electronic record that medical staff are able to enter it so that it then becomes known in the patient's chart, even beyond medical in their classification file, that this is on record for them.

Q. Has a medical lay-in ever been used to provide an inmate access to an item that they typically would not be allowed to have?

A. Yes.

Q. And the next sentence says: "The committee also discussed this offender's request for a hair removal device, which the committee found not to be medically necessary at that time."

Why did the committee determine that a hair removal device was not medically necessary at that time?

A. At the time and still today, we would like for Ms. Hicklin to receive hormone replacement therapy. And as I stated, we will continue to assess all of the other needs, but we really would like to begin that treatment for her and see where things go.

Q. I think you indicated that you're familiar with the WPATH standards of care.

A. Yes.

Q. And are you aware of the fact that according to those WPATH Standards of Care, for male to female transgender individuals, hormone treatment is not likely to result in complete removal of unwanted hair?

A. Generally, I have that understanding.

Q. So you understand that even if Ms. Hicklin receives hormone treatment, in order for her to have

all of the unwanted hair removed, she'd still have to have some sort of hair removal treatment?

A. She'd still have to work to remove the undesirable hair, yes.

Q. Okay. So I'm going so ask the court reporter to mark six separate exhibits that are job descriptions that were provided to us by counsel for Corizon this morning just as we started this deposition.

MS. BUTLER: And I only have one copy of each of these.

(Deposition Exhibit Nos. 109 through 115 were marked for identification.)

Q. (By Ms. Butler) So before we move on to those exhibits, I want to go back to Exhibit 107, which are the meeting minutes from September 21, 2015. I can't remember if I asked you this initial question, and that's whether Ms. Hicklin was discussed during any other of these Monday meetings.

A. In my recollection, only the one that I mentioned to you previously late, December 2017.

Q. Are there minutes for that meeting, that December 2017 meeting?

A. I would believe so.

Q. Minutes are kept for each of these Monday

EXHIBIT

U

THOMAS KEVIN BREDEMAN, DO

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MISSOURI

EASTERN DIVISION

JESSICA HICKLIN,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No.
	)	4:16-CV-01357-NCC
	)	
ANNE PRECYTHE, et al. ,	)	
	)	
Defendants.	)	

Jefferson City, MO

DEPOSITION OF THOMAS KEVIN BREDEMAN, DO

TAKEN ON BEHALF OF THE PLAINTIFF

February 7, 2018

Reported by: Lisa Ballalatak

Job No. 137273

Q. Have you ever met with Ms. Hicklin?

A. No. Not to my knowledge.

Q. Over the last two years, aside from your OB/GYN patient interactions, can you estimate the number of individuals -- patients -- that you've met with directly?

A. No.

Q. About how many patients do you meet with directly, outside of your OB/GYN capacity, on a monthly basis?

A. Most months, zero.

Q. Have there been months over the last two years where you've met with patients directly, outside of your OB/GYN duties, more than five times?

A. In November of 2017, I was on-site at the Algoa Correctional Center twice to see patients, and in November of 2016, I was at Women's Eastern Reception and Diagnostic Correctional Center with a group of providers to see patients.

Q. Any other months that you've seen more than five?

A. Not to my memory.

Q. And what was the purpose of you being on-site in November of 2017 at Algoa Correctional

hair follicle from a fine wispy-type of hair to a coarse whisker-type of hair.

Q. So it hinders the development of new body hair from fine body hair to courser body hair; is that correct?

A. Correct.

Q. Okay. And then you also list here, "Slower loss of scalp hair." Is that referring to if, for example, an individual has male pattern baldness?

A. Yes.

Q. That will reverse that baldness, or will it --

A. Delay.

Q. It'll delay it?

A. The advancement of that baldness.

Q. Understood. And as to facial hair -- so is it accurate that the male to female hormone therapy won't get rid of facial hair; it'll just reduce the coarseness of it?

A. It will prevent or delay further transition from fine hair to coarse hair. So it doesn't -- you can't go back. Once a hair follicle produces, the coarse-type of hair, you can't reverse

that and get it back to a fine hair. So the goal of the therapy is to just prevent further coarse hair growth from occurring.

Q. Understood.

A. But whatever coarse hair is there will be there forever.

Q. If you'll look at the last page of Exhibit 118. And I just want to get a sense of the -- you have the standard therapy and dosages listed there. Where did you get those dosages from?

A. Again, it would have been either WPATH or UpToDate.

Q. Okay. I'm going to hand you what has been marked Exhibit 117 for your deposition. Is that a document that you've seen before?

A. Based on my signature at the bottom of the document, I would say yes.

Q. When is the last time you saw this document?

A. I would presume it would have been around October of 2014.

Q. Because that's the date that it was signed?

A. Yes.

EXHIBIT

V

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN, Plaintiff, v. ANNE PRECYNTHE, et al., Defendants.	Case No: 4:16-CV-01357-NCC

DEPOSITION OF GLEN BABICH, M.D.

Monday, January 15, 2018

Tempe, Arizona

9:00 a.m.

JOB NO. 135748
Prepared by:
Marcella Daughtry, RPR
Arizona CR No. 50623

different forms, where it's in some document that you can go back to and say, okay, you know, here it is.

Q And would the evaluation that led to that valid diagnosis have included a real-time interaction with the patient?

A Yes, or a review of -- I mean, somewhere there would have been a real time, whether it was by that provider or whether them relating other information, yes.

Q Understood. Do you know Jessica Hicklin?

A No.

Q You've never met her?

A No.

Q Never spoken with her?

A No.

Q Never done a medical consult or evaluation of her?

A No.

Q Have you spoken to healthcare providers who have directly interacted with Ms. Hicklin?

A Yes.

Q Who?

A Dr. McKinney.

Q Who else? Anyone else?

A No.