IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

STACIE RAY, BASIL ARGENTO, JANE DOE and ASHLEY BREDA, Plaintiffs,	)	
vs	)	No. 2:18-cv-00272-MHW-CMV
AMY ACTON, in her official capacity as DIRECTOR OF THE OHIO DEPARTMENT OF HEALTH, KAREN SORRELL, in her official capacity as CHIEF OF THE OFFICE OF VITAL STATISTICS, and JUDITH NAGY, in her official capacity as STATE REGISTRAR OF THE OFFICE OF VITAL STATISTICS, Defendants.	)	

The deposition of RANDI ETTNER, Ph.D. called for examination pursuant to notice and pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions taken before MARI BETH KAWULIA, Certified Shorthand Reporter within and for the County of Cook and State of Illinois at 105 West Adams Street, Chicago, Illinois, on September 18, 2019 at the hour of 10:00 a.m.

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REPORTED BY: MARI BETH KAWULIA
CSR LICENSE: 084-2873

I N D E X

WITNESS:
RANDI ETTNER, Ph.D.

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(Witness duly sworn.)

WHEREUPON:

RANDI ETTNER, Ph.D.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

D I R E C T E X A M I N A T I O N

BY MR. BLAKE:

Q. All right. My name is Jason Blake. I am an attorney at Calfee, Halter & Griswold, LLP, and I represent the Department of Health, among others, in this litigation.

Could you please state and spell your name for the record?

A. Randi Ettner, R-a-n-d-i, E-t-t-n-e-r.

Q. And are you here to testify regarding your expert opinion that you rendered in the case of Stacie Ray, et al versus the Director of the Ohio Department of Health, et al?

A. I am.

Q. I suspect it won't be necessary to gather or collect you at your address at any time because I'll contact you through counsel, but could you just state the best way to get ahold of you, your business address or your home address or

something, something where we can reach you if we need to?

A. 1214 Lake Street in Evanston, Illinois. The zip code is 60201.

Q. Great. Thank you.

I guess before we dive in, from your resume and your CV and just, you know, what I learned about you before the deposition, I assume you've given a number of depositions before, right?

A. That's correct.

Q. So we probably don't need to go into any great detail about the rules and sort of the procedures, but just to kind of reinforce some of the basic stuff, it's your deposition. If you need to stop at any time to take a break, please do so. Just let me know, we'll stop. The only caveat to that is if a question is pending, I would ask that you answer the question and then we can stop.

I think probably you have enough experience to sort of -- we can do the basic blocking and tackling of a deposition, but if there's any confusion or something like that, please let me know. If you answer a question, I'm

going to assume that you understood the question.

What are your areas of expertise in which you are qualified in your opinion to give expert testimony?

A. I'm qualified in general psychology, tests and measurements, PTSD and trauma, all areas of gender and gender diversity and adult psychotherapy.

Q. PTSD, that's post-traumatic stress disorder?

A. Correct.

Q. Tests and measurements, what's that?

A. Psychologists are trained to give psychodiagnostic tests.

Q. So could you give me an example?

A. IQ test, personality tests, tests about measurements of anxiety, depression and other various disorders as well as tests to determine neurocognitive abilities or the lack thereof.

Q. Okay. I assume there's lots of overlap between these four areas, but would a diagnosis of gender dysphoria fall underneath one of the tests and measurements that you're qualified to render?

A. No. There is no test for gender

dysphoria per se.

Q. All right. So what -- I mean, my understanding is that the plaintiffs in this case have a diagnosis of gender dysphoria, is that your understanding?

A. That's my understanding.

Q. What is the difference between the kind of -- I mean, somebody rendered that diagnosis of them. So what's the difference between the type of diagnosis that would fall under a test and measurement and one like gender dysphoria where there is no test or measurement?

A. Well, tests and measurements can measure many things, extroversion, introversion, so they can measure aspects of personality, and that differs from diagnosable disorders. Diagnoses are typically made on criteria outlined in a diagnostic and statistical manual.

Q. Like a DSM?

A. Correct.

Q. So a diagnosis like severe anxiety or depression, would that be subject to a test or measurement or would that be something different?

A. One could use a test to determine a

specific profile because everyone experiences anxiety in a different way, but it would meet the criteria of an anxiety disorder if it followed the DSM-5 criteria.

Q. Okay. Well, you can tell me. Are there criteria in the DSM-5 for gender dysphoria?

A. Yes.

Q. So then what I guess separates a diagnosis of -- We're just going to stick with severe anxiety because that's what we've been talking about. You said that one was subject to tests and measurements yet gender dysphoria isn't subject to any test or measurement.

What is the reason for I guess the difference between the two?

A. Gender dysphoria has attendant anxiety as one of the symptoms, as does post-traumatic stress disorder.

Q. Sure.

A. So anxiety, depression and hopelessness underlie many psychiatric or other disorders that are listed in the DSM-5.

Q. Okay. So the diagnosis of gender dysphoria would include some sort of like

sub-diagnoses for things like anxiety and you said hopelessness. Those sub-diagnoses may involve some tests or measurements which help point you in the direction of getting to a diagnosis of gender dysphoria, but specifically there's no test or measurement for that diagnosis of gender dysphoria; is that accurate?

A. I'm not sure I understand that question the way you phrased it.

Q. Sure. I'm just trying to flush out what you meant when you said that a diagnosis of gender dysphoria wouldn't fall under a test and measurement, you know, that sort of expertise that you have. And the reason for that was, I'm sorry, can you say that again?

A. Well, by analogy, there's no test per se of anorexia nervosa, but we can make the diagnosis by following the criteria that are outlined, but anxiety and depression are broad parameters that underline many, if not most, psychiatric or other disorders that are listed in the DSM-5. Does that clarify it for you?

Q. Yeah. Maybe. I guess it just exposes my ignorance about, you know, the vast array of

diagnoses that you can receive from a psychiatrist or psychologist. The witness is nodding her head yes I assume in response to my self diagnosis of ignorance of her field.

But is it fair to say that not every diagnosis, clinical or otherwise, in your field is not subject to, you know, a strict, you know, test? Is that fair to say?

A. Would you repeat that question? I'm sorry.

Q. Sure. I'm not trying to trip you up.

A. I didn't understand it the way it's phrased.

Q. That's fine. You brought up anorexia, and we can talk about anorexia in this context too just a bit -- you know, it's more separate from the facts of this case. Again, I'm not trying to, you know, blind side anybody with some "got you" question. I'm just trying to understand, you know.

Let's say I show up, right, in your office and I start, you know, telling you what I'm experiencing, and based on what I've told you, you're like hmmm, I think this person might be an

anorexic. Are you with me so far?

A. Yes.

Q. Or anorexic or someone that has anorexia, right?

A. I'm understanding this part of the statement.

Q. Okay. There's not any -- you know, you can't do a blood test to say, yeah, this person has anorexia; is that correct?

A. That's correct.

Q. You can't look for any, you know, concrete evaluative, you know, metrics and say that yep, that's anorexic, right?

A. There are some metrics that I might look for, but if you came to my office, I would make the diagnosis without giving you a statistically reliable and valid psychometric instrument.

Q. Okay. And that doesn't in your mind undermine the credibility of that diagnosis, it just informs someone in your profession or from the outside on how the diagnosis was reached, right?

A. Most tests are not used to make a diagnosis. They're used to give some indication

about an individual, either about their personality or about perhaps certain behaviors, but they don't in and of themselves make diagnoses.

Q. Okay. Understood. So you would -- you could give a test to someone and say this person is suffering from severe anxiety and that might be a criteria for any number of other diagnoses that you could reach given the circumstance of the patient?

A. I think I agree with that statement.

Q. Okay. Good. And then I expect that you will have a personality evaluation of everyone in the room before you leave today. I wouldn't know.

A. Only if you all have the appropriate insurance.

Q. Well, I can tell you my insurance is terrible.

A. Then you will not get any sort of analysis.

Q. No free analysis, okay. I'm stuck to my online quizzes figuring out which Hogwarts house I'm in.

So general psychology, PTSD, tests

and measurements and then you said gender and gender diversity, right?

A. Correct.

Q. Does your opinion that you rendered in this case stem largely from your expertise in the field of gender and gender diversity?

A. Yes.

Q. Okay. Like I said, I assume there's some overlap with your general knowledge of psychology and probably the tests and measurements too, I would guess, right?

A. I imagine that all of my experience has lead me to a certain degree of competence.

Q. How long have you -- I suppose how long have you practiced psychology?

A. I've had a private practice since 1980.

Q. And before that you received your degree, right?

A. That's correct.

Q. And you have a Ph.D., right?

A. Yes.

Q. You received a masters as well?

A. Yes.

Q. Kind of the normal four-year degree

masters, Ph.D. track program, right?

A. Yes.

Q. And then for a time you -- did you work like in residency like at a clinical hospital or anything like that?

A. I've done postdoctoral work in certain areas.

Q. Okay. And then after doing that for a period of time, you set up your own private practice; is that accurate?

A. In 1980 I began practicing privately.

Q. Okay. And when did you first start developing your expertise in gender and gender diversity issues?

A. As a young student I volunteered at Cook County Hospital and they were running groups for individuals who wanted what was then called sex change or sex reassignment surgery, and since I was the first volunteer they had ever had, I was sort of like a candy striper back then, they said we'll stick her with those people.

So before I had a degree, I was involved in groups of individuals who were awaiting reassignment surgery, and that's my first

experience with people who were experiencing gender incongruity.

Q. Okay. And that would have been approximately?

A. In the late '70s.

Q. Was that during your doctoral?

A. No.

Q. Before that?

A. Yes.

Q. Masters?

A. Before.

Q. So as an undergrad?

A. Yes.

Q. Okay. I know you identified in your CV, and we'll get to those in a few minutes, some of your recent cases that you have been an expert witness in and been deposed in.

Do you know approximately how many times you have been an expert witness in any sort of matter in the last ten years?

A. I could only make a guess about that.

Q. I'm okay with that. I'm not going to ask you okay, you know, the first time, the second time. Just approximately, you know, is it 15? Is

it 20? Is it 30?

A. It's probably closer to 50.

Q. Somewhere between 30 and 50 you think?

A. I would say it's probably more than 30.

Q. Okay. More than 30, less than 50?

MS. INGELHART: Excuse me. Just really quickly, we would like to add a couple developments to the record since she shared her CV with you all.

Recently she's given testimony in a new case, new to her, to her C.V., a case called Monroe v. Jeffries which she can talk about. She's also been invited to speak with the Director of the Office of Civil Rights at the Federal Department of HHS. And to her bibliography, to her report, a study was omitted in error.

MR. BLAKE: I'm sorry?

MS. INGELHART: To the bibliography of her report, a study was omitted in error that she relied upon.

MR. BLAKE: Okay.

MS. INGELHART: It is cited in Dr. Gorton's report for the full citation, but it's the Bauer G.R., et al 2015 study, "Intervenable

Factors Associated with Suicide Risk in Transgender Persons, a Respondent Driven Sampling Study in Ontario, Canada."

BY MR. BLAKE:

Q. This is the 2015 study that found that transgender individuals have a higher rate of suicide when they have documents that don't match their gender identity; is that right?

A. That's correct.

MR. BLAKE: Okay. We're going to talk about that, and I did pick up that it wasn't cited in her report, and I was going to ask her what report she was referring to. I assumed it was the Gorton one or the Bauer one that Gorton refers to. Thank you for clearing that up.

MS. INGELHART: Thank you.

MR. BLAKE: We'll talk about that report, that study later.

BY MR. BLAKE:

Q. All right. So you think somewhere between 30 and 50 times you've served as an expert witness, closer to 50 than 30. Generally what types of matters have those cases involved?

A. Personal injury, correctional systems,

employment discrimination, the necessity of identity documents, trauma, post-traumatic stress disorder, medical malpractice, and I think to the best of my recollection -- oh, and insurance cases including the Medicare -- overturning the Medicare exclusion for gender confirmation surgery case, bathroom cases.

Q. Okay. Have all of these cases been in the context of like transgender issues, transgender people or have some of them been just general psychology expertise type cases?

A. The latter.

Q. So all of these are gender -- all of these you would qualify as falling -- oh, sorry. So they all fall under obviously your expertise in general psychology, right?

A. They don't all involve transgender plaintiffs or defendants.

Q. They don't all involve your expertise with gender and gender diversity?

A. That's correct.

Q. Okay. Which I think we can both agree that this case, I think you were going to testify to this, would fall primarily under your expertise

for gender and gender diversity, right?

A. Correct.

Q. What portion of these cases, these 30 to 50 cases and these roughly eight different areas would you say fall primarily under your expertise in gender and gender diversity?

A. I would be offering a guesstimate at best.

Q. Okay. Is it a quarter, 25 percent?

A. I want to qualify this by saying when I began doing expert witness work, I didn't keep track of the cases that I was involved in.

Q. Sure.

A. So I would say that early on I did a lot of personal injury work.

Q. Okay. And those would be more like emotional harm, emotional distress type cases. Some of those folks may have, in fact, been transgender, but it wouldn't be part of the case, right?

A. Correct. And medical malpractice cases, some cases about malingering, things of that nature.

Q. Okay. What about your cases dealing

with correctional institutes?

A. I frequently have testified in cases in correctional institutes.

Q. And are those involving gender and gender identity issues?

A. Yes.

Q. Employment discrimination, is that primarily gender and gender diversity issues?

A. Primarily.

Q. Necessity of ID, right, that's like this case, right?

A. Yes.

Q. Gender and gender diversity issues in those cases?

A. Yes.

Q. How many of those cases have you done?

A. I would need to count, if I may. Would you give me a minute?

Q. Are they the ones that you've identified in your CV?

A. I haven't identified any cases in my CV.

Q. Okay. Maybe in your report I mean. Are those the ones that you've identified in your report? You don't know?

A. I'm -- I was the expert witness in the Puerto Rico case, in the Idaho case, in the Michigan case.

Q. This is the -- the Michigan case is the driver's license case?

A. Yes. And perhaps that's all.

Q. Did you sit for a deposition in the Idaho case?

A. I did not.

Q. What about in the Puerto Rico case?

A. No.

Q. What about in the Michigan case?

A. No.

Q. Is this the first time that you've been deposed in a what you term necessity of ID case in the gender and gender diversity area of expertise?

A. Yes.

MS. INGELHART: Excuse me.

MR. BLAKE: Hold on a second.

MS. INGELHART: Okay.

MR. BLAKE: And if you're going to bring up the cases that are in her CV, we're going to go through those one by one, so there's an opportunity for her to correct the record, that's fine.

MS. INGELHART: Sure. I mean, if we're just going to be going through her report or through these documents, I think we would like them to be introduced as exhibits or else we're kind of --

MR. BLAKE: We are going to be introducing them as exhibits.

MS. INGELHART: Okay. Because these questions are close to --

MR. BLAKE: I'm just trying to get her background information. She didn't need to tell me the actual cases, just a number. You know, it could have been five or three. Just trying to get a general sense.

MS. INGELHART: Thank you.

BY MR. BLAKE:

Q. The PTSD cases, probably not gender diversity cases or are they?

A. Some are and some aren't.

Q. Some people have been harmed or discriminated against and as a result of that discrimination, they've developed some post-traumatic stress disorder related to their gender discrimination, does that encapsulate those

cases?

A. Would you repeat that question?

Q. Yeah. I'm just trying to -- you know, PTSD, right, I guess famously is, you know, what returning soldiers suffer when they go to war, right, and they come back and they've experienced some traumatic event and they have post-traumatic stress disorder. There are, I understand, areas where people can suffer PTSD, right?

A. PTSD or trauma.

Q. Okay. And you said that some of these PTSD cases arise in the context of your expertise with gender and gender diversity, right?

A. Some. The majority did not.

Q. Well, I guess instead of me trying to guess, I guess sort of, if you can, generally tell me how or under what circumstances your testimony in PTSD cases overlaps with your expertise of gender and gender diversity issues.

A. I'm sorry, I'm going to ask you to repeat that question again.

Q. That's fine. I don't mind.

You have been used as an expert in cases involving post-traumatic stress disorder,

correct?

A. Correct.

Q. Some of those cases have involved gender and gender diversity issues, correct?

A. I would say some of those cases have involved people who are transgender and who experienced post-traumatic stress disorder.

Q. Okay. Can you just generally explain the circumstances I suppose that caused the post-traumatic stress disorder?

A. I can tell you that they differed in every case.

Q. Okay.

A. For instance, a transgender person was killed in one instance. In other instances, people were threatened with death and physically harmed. People were harassed and tormented, victimized, discriminated against in many, many different ways, in many different scenarios, and each case was different in terms of the particulars of the harms that were done.

Q. Right. So is the diagnosis of PTSD with a transgender person any different than a diagnosis that you see like, for example, of a returning

soldier or a family member who's lost a loved one in a traumatic way or is sort of the -- are the symptoms and the sort of the diagnosis and the harm basically the same?

A. The criteria for making a diagnosis of PTSD is published in the DSM-5, however, every person who experiences trauma or PTSD has a different trauma profile. So people do not experience the same symptoms, even though they may all have the same diagnoses.

Q. Okay. Is there anything unique about your expertise in the field -- in the area of gender and gender diversity that allows you to, I hate to qualify it, but, you know, make a better diagnosis of a transgender person who has suffered PTSD or would anyone who has a psychology background, you know, with the requisite experience be able to make that diagnosis on a transgender individual?

A. Again, I'm sorry, I don't understand the question the way you phrased it.

Q. You said there was a criteria in the DSM-5 for PTSD. The way in which you apply that criteria to a transgender person isn't any

different than you would apply that criteria to a cisgender person, right?

A. Correct.

Q. Okay. You mentioned the medical mal stuff occurred earlier in your career. Is there any overlap between the medical mal expertise or expert testimony you've given and your gender and gender diversity expertise?

A. I was disclosed as an expert in a case on behalf of the defense in a medical malpractice lawsuit that was being brought by a transgender person against a surgeon.

Q. And was the surgery, like was it part of their transition or was it just routine surgery like they had to have their spleen removed or something?

A. It was a gender affirming procedure.

Q. Gender affirming procedure, okay.

And the plaintiff was the patient and they were alleging that the surgeon providing the operation somehow breached the standard of care? Does that sum it up at a very high level?

A. No.

Q. Okay.

A. I would characterize it as they were unhappy with the outcome of the surgery. The surgeon did not breach the standard of care and advised the patient that the adverse outcome she experienced was a possibility and very often occurred with the particular surgery she was undergoing and the case settled.

Q. Okay. Insurance cases, let's set aside the Medicare one for the time being where you talked about, you know, I guess the scrubbing of gender confirmation surgery from the -- is it from ObamaCare, is that what that was about?

A. In 2014, May 30th of 2014 the Medicare exclusion of gender surgery was reversed.

Q. Okay. So setting that one aside for now, are there other insurance cases you've been involved in?

A. Yes.

Q. What are the nature of those cases?

A. I don't think I can talk about those cases because they're ongoing.

Q. Okay. So you've got some ongoing cases that involve insurance. Do they fall within your expertise of gender and gender diversity?

A. Yes.
Q. Approximately how many?
A. Approximately three.
Q. Are you plaintiff? Do you represent the plaintiff or an expert for the plaintiff or the defendant?
A. Plaintiff.
Q. And are they cases against government or insurance companies?
A. Both.
Q. Is the general premise of those cases a claim involving either refusal of coverage or refusal to reimburse for various procedures associated with someone's gender affirmation?
MS. INGELHART: I'm just going to object. You know, answer to the extent you can without breaching that expert attorney privilege, that work product privilege.
BY MR. BLAKE:
Q. I just want to say for the record I haven't asked for the names of the cases, the agencies involved or the governments. I think we are still at a very high level to where, you know, just getting the general issues, the general claims

is not going to encroach upon any breach of confidentiality, but go ahead.

A. What was the question again?

Q. Yeah, I asked whether or not that the issue in those cases, whether it involved a claim that the agency or government or insurance company wrongfully refused coverage or reimbursement for a procedure involving gender affirmation.

A. That's probably fair, a fair way to characterize two of the three cases.

Q. Okay. So that seems in line I suppose with your work for the Medicare case where they reversed the coverage for gender affirmation surgery, right?

A. I'm not certain what you mean by in line.

Q. It's a similar -- it sounds like a similar issue, right, your expertise in that area, you know, you've got the Medicare cases and these other cases that you are working with these three that were talking about, those issues have some overlap?

A. I think that's true.

Q. Okay. The bathroom cases, how many of

those have you been involved in?

A. One bathroom case -- two bathroom cases and two locker room cases, locker room/bathroom cases, sex segregated facility cases.

Q. So a total of four?

A. I think that's accurate.

Q. I don't want to split hairs between bathrooms and locker rooms.

A. And I don't want to be overly precise about the number because --

Q. That's fine.

A. -- I may not be recalling accurately.

Q. I'm not going to impeach you based on -- like your counsel said, you know, this is -- some of this stuff is disclosed in your --

A. Actually it's more like five because I recall now.

Q. Okay. Five. Generally those cases involve --

A. Six.

Q. It's growing. It's going to be 40 by the end of the deposition.

So those cases, those six, the ever increasingly inaccurately in four locker room

cases, bathroom cases, those generally involve a transgender person who's seeking access to one of those facilities and is denied the access to the bathroom that they -- that matches their gender identity. Is that more or less accurate?

A. Yes.

Q. I think I understand those. Those ones have been heavily publicized.

Have you ever served as an expert witness for Stacie Ray or any of the other plaintiffs in this case?

A. No.

Q. Have you ever served as an expert witness for any of the counsel sitting next to you?

MS. INGELHART: Objection. Answer to the extent that you can, not disclosing expert and attorney work product to the best of your ability.

BY THE WITNESS:

A. I have been an expert in cases where I've been retained by the firms that these attorneys are employed by, but I've not met either of these individuals before or been involved with them prior.

BY MR. BLAKE:

Q. Okay. That was my next question. Setting aside Kara and Elizabeth, have you ever been retained by the ACLU or Lambda Legal?

A. Yes.

Q. All right. Approximately how many times have you been retained by the ACLU?

A. In different states primarily in connection with prison work.

Q. Approximately how many times?

A. I have to count on my fingers.

Q. Go ahead and count. And approximately can be, you know, 5 to 10, 10 to 15, a dozen or so.

A. The difficulty I'm having is that it's my understanding, and I'm not an attorney, that sometimes there's a collaboration and I'm not always aware of who is retaining me or what other firms are involved.

Q. Understood.

A. So I'm not really sure how to answer that. I recently did a case where I was hired by the ACLU and it was the case that was just mentioned, Monroe v. Jeffries, et al, and there was another law firm that was co-counsel.

Q. Understood. Well, let me ask it this way then. Maybe this will make it easier for you.

All right. You said you've been an expert 30 to 50 times, closer to 50 than 30. Can we just call it 41, 42? Can we call it 42?

A. Let's call it 48.

Q. 48, okay. Much closer to 50. All right. So approximately 48 times you've been an expert witness before.

A. In the past ten years.

Q. In the past ten years.

Do you know approximately what percentage of those 48 cases have involved either the ACLU or Lambda Legal?

A. No, I don't know.

Q. You have no idea?

A. I would have to make a guess.

Q. Okay. Do you think it's greater or less than 50 percent?

A. Less.

Q. Do you think it's greater or less than 25 percent?

A. Combining those two organizations?

Q. Correct.

A. I would say less.
Q. Still less, okay. So a handful of times you've been retained by ACLU or Lambda Legal?
A. Yes. Probably more by the ACLU because they have offices in every state, and I've gone to prisons in some of those states. I would also like to amend something I said earlier.
Q. Is it now seven bathroom and locker room cases?
A. No. There's an immigration case in there.
Q. Okay. Immigration. Did that involve gender and gender diversity issues?
A. Yes.
Q. How?
A. A transgender person was seeking asylum in the United States.
Q. Okay. And how did the transgender -- how did their gender identity have any impact on whether or not they were entitled to asylum?
A. They were being persecuted in their country of origin, and the other transgender people they had been associating with had been killed or threatened, and they were told that if they weren't

going to carry drugs or perform sex acts with the police that they would be murdered, so they fled their country and sought asylum here.

Q. Were they granted asylum?

A. Yes.

Q. That's good news, right? That's good.

You mentioned one medical mal case where you were retained by the defendant. Of those 48 cases or so over the last ten years, how many times have you been retained by defense counsel?

A. In the past, quite a bit actually. There was a -- there is a Chicago firm, a defense firm that I did a number of cases with.

Q. Were those all in the context of medical malpractice?

A. No, they weren't, but they were all -- one was personal injury -- a couple were personal injury cases as I recall.

Q. Have you ever been retained as an expert witness by the defendant -- Strike that.

You mentioned one medical malpractice case when you were retained by the defendant and that case involved some gender or gender diversity issues, right?

A. Are you referring to the case I described where a transgender individual had a procedure and filed a lawsuit against a physician?

Q. Yes.

A. Yes.

Q. Thank you.

Are there any other gender, transgender, gender identity cases where you have represented or been called as an expert by the defense?

A. I've been asked to be an expert in some cases, but I did not -- I wasn't disclosed as an expert.

Q. So you've never been at least retained as a testifying expert in any cases for defendants involving gender issues except for the one medical malpractice case that we've already discussed?

A. Correct.

Q. Have you -- Well, the 48 cases or so that we have talked about, does that include testifying and nontestifying expert?

A. Yes.

Q. Okay. Do you know approximately the proportion of those 48 cases where you've been

called as a testifying expert?

A. By testifying, are you --

Q. An expert that would be disclosed.

A. Oh, I was disclosed in all those cases.

Q. You were disclosed in all 48?

A. Yes, but I didn't offer testimony in all 48.

Q. Is that because the case just didn't get that far?

A. In some cases I gave a report and in some cases the case settled or I simply didn't testify.

Q. So had those cases gone to trial, those 48, you would have testified at some point, likely your deposition would have been taken or you would have been called as a witness or something like that, right?

A. Correct.

Q. At least that was your understanding?

A. That was my understanding.

Q. So you mentioned that you've been asked by defendants to be an expert but ended up not giving testimony. Is that because the case settled or just somehow was disposed of before you had the

opportunity to testify or were you just a consultant?

A. A consultant. I reviewed the records and didn't feel that my expertise would be meaningful in that case.

Q. Is that because you didn't have the requisite expertise or you disagreed with the position that the defendant was taking?

A. Probably both.

Q. And all those cases were in the context of a gender and gender diversity, your gender and gender diversity expertise, right?

A. I'm sorry, in all what cases?

Q. The cases where you were asked, reviewed the record and declined to be the expert, were all those cases gender and gender diversity cases?

A. No.

Q. Okay. Are they just kind of spread kind of generally all around the areas that you have testified in?

A. The ones that I'm recalling were in the areas of medical malpractice and trauma, personal injury.

Q. Okay. So never a case like this one

where you talk about, you know, an ID case, right, the necessity of an ID?

A. Right.

Q. Or what about any other challenge to a government regulation or law or anything like that?

A. I'm sorry, I don't understand what you're asking me.

Q. Let me ask you this: Have you ever served as an expert witness in a case involving a challenge to a law?

A. To a law?

Q. Yes.

A. I believe that I'm involved in cases now that challenge the law.

Q. Okay. And again I'm not trying to be tricky. You know, I can ask the same question I suppose with regards to regulations and policies and things of that nature, but, I mean, for your purposes, do you really distinguish between those three?

A. Yes.

Q. Okay. So then same question, have you ever served as an expert witness in a case

involving a challenge to a governmental regulation?

A. Presently, yes.

Q. Presently. And I guess I should say not counting this case, all right, because I don't know, but, you know, some of the other cases that you're talking about that you've been hired to be an expert challenging a law or regulation.

A. I guess I'm unclear about legally what's meant by regulation.

Q. Sure. Let's just talk about cases then where the government is a defendant. You mentioned the Idaho case, the Puerto Rico case, the Michigan case and this case, right?

A. Yes.

Q. Are there any other cases where you've been retained as a testifying expert where a government, federal, state, local or otherwise was the defendant?

A. I believe so.

Q. Of those cases where the government was the defendant, how many involved gender transgender, gender diversity issues?

A. I'm having some difficulty with this question. I can say for certainty that, for

example, I was an expert witness in a case where Chelsea Manning was involved in a lawsuit against the government so that's clear to me, and many times, oftentimes I'm involved in cases that challenge state department of correction policies.

Q. I was going to ask, right, do a lot of these occur in the context of your work in the corrections field?

A. Many, many do.

Q. Okay. And a lot of those are gender cases?

A. Right. I also think that my opinion is, and I hope that someone will correct me if I'm speaking out of turn, that it's okay to disclose I was the expert in the North Carolina case which was against I think proposed law or regulation. I'm not sure.

Q. Right. I think that law was enacted, but then it was stayed and then it went up and then it went down.

A. Right. And the Graham Grimm.

Q. I think you're right, Grimm.

A. Graham?

Q. I think Grimm was the plaintiff.

MS. INGELHART: Gavin.

MR. BLAKE: Gavin Grimm.

THE WITNESS: Gavin Grimm, that case. And the immigration case was against the government.

BY MR. BLAKE:

Q. Have you ever been an expert witness, and you said there were many, many cases where the government has been a defendant. Have you ever been retained as an expert by a government in a case either on the plaintiff or defendant's side?

A. I've been a court appointed expert.

Q. In what case were you a court appointed expert?

A. In Sania versus Turko.

Q. What did that case --

A. I think at that time I think it was Sania versus Bender. It was a prison case.

Q. Okay. Do you get a lot of your correction cases through court appointments?

A. No.

Q. How many court appointed cases have you had?

A. I think that was the only time that the

court actually appointed me as an expert.

Q. Okay. So there was one time the court just knew about your work in the corrections field, appointed you as an expert and the party that you happen to represent or be an expert for was government, right?

MS. INGELHART: Objection, mischaracterizes her prior testimony. You can answer.

BY THE WITNESS:

A. I don't think that's an accurate characterization.

BY MR. BLAKE:

Q. Okay. Well, I guess was that -- what state was that for?

A. Massachusetts.

Q. Okay. Did that case involve a transgender individual?

A. Yes.

Q. Was the transgender individual the plaintiff or the defendant?

A. Plaintiff.

Q. And they were seeking some claim against state government, right?

A. Correct, Department of Corrections.
Q. And how did you get called as a -- how did you get appointed by the court?
A. The experts that had been previously testifying in the case had been going back and forth for approximately ten years and the judge determined that it was time to bring in an independent expert.
Q. So you were like the tie breaker?
A. I was the tie breaker but then unfortunately the judge retired and so the case went back to the beginning, but then a new firm hired me since I had experience with the plaintiff who constantly needed to be evaluated.
I'm going to ask for a brief break, and I'm going to ask if someone would refill my water.
Q. Sure.
(Whereupon, a short break in the proceedings was taken.)
MR. BLAKE: Back on the record.
BY MR. BLAKE:
Q. Just to recap, the only case where you've represented a government entity is this

Massachusetts case involving the corrections issues, right?

A. No.

Q. Okay. You've represented the government in other cases -- Sorry. Represent is the wrong word. You've been an expert for the government in other cases?

A. I wasn't an expert for government in that case.

Q. You weren't?

A. No. I was appointed by the court.

Q. But not for or against the government, you were just like a --

A. Independent.

Q. Special master, does that ring a bell?

A. No.

Q. Okay. It's not important. Thank you for clarifying that.

So have you ever been an expert on behalf of any government?

A. No.

Q. So I take it whenever you've been an expert and the government has been a defendant, your opinion has always been that the government is

liable or in the wrong; is that accurate?

MS. INGELHART: Objection, vague. You can answer. Objection, that also calls for a legal conclusion, but you can answer.

BY THE WITNESS:

A. I've been retained by the plaintiff and some of those cases have involved state or federal agencies that were defendants.

BY MR. BLAKE:

Q. And you've always provided expert opinions that support the party that retains you, right? Is that a fair assumption?

A. No, not if I don't -- if my opinions or if the information that I reviewed doesn't comport with my opinion, then no.

Q. Has your opinion ever supported the position of the state or federal government in those cases you've mentioned where those entities are defendants?

A. In some cases I've refused to be an expert because after reviewing or hearing the case, I have not felt that I could opine in a way that would allow the plaintiff to be successful in their lawsuit.

Q. To prevail?
A. Uh-huh.
Q. Have any of the cases where you've refused to be an expert for the plaintiff, have any of those cases involved a government defendant?
A. I don't know.
Q. You can't recall any?
A. I can't recall.
Q. Have any of the cases where you've refused to be an expert for the plaintiff involve transgender issues?
A. Yes.
Q. Do you know approximately how many times?
A. I know at least two or three times.
Q. Did any of those cases involve -- Well, can you tell me what category of cases those involved? Were they PI cases, correction cases, discrimination cases?
A. They were correction cases and PI cases.
Q. You've rendered an opinion in this case, right?
A. Yes.

Q. Have you been asked to provide your expert opinion on how the Department of Health's refusal to change the sex identifier on a birth certificate based on an individual's gender identity affects transgender individuals?

A. Yes.

Q. Did you conclude that not having a birth certificate that reflects a person's gender identity causes such individuals harm?

A. Yes.

Q. Is that the only opinion you were asked to render in this matter?

MS. INGELHART: Objection, vague, attorney work product. Answer to the extent you can do so without revealing communications with --

MR. BLAKE: I will retract the question.

BY MR. BLAKE:

Q. Did you render any other opinion in this matter?

A. That was the primary opinion that I was -- primarily what I was asked to opine on.

Q. And did you reduce that opinion and any sub-opinions into writing?

A. I produced a report in this case.

Q. And that's where all of your expert opinions are reflected in the report, right?

A. Yes.

Q. You are being compensated for rendering your opinion in this matter, right?

A. Yes.

Q. We can look at the report, if you want. I think you disclose what the -- it's not in that stack of documents, but do you just offhand recall what your rate of compensation is? If you want to refer to your report, I'm happy to provide it to you too.

A. Well, I would prefer to refer to the report. I recall that my fee for generating the report was $400 per hour.

Q. Okay. Do you have any idea what you've billed to date?

A. Not offhand I do not.

MR. BLAKE: Okay. This is going to be Exhibit 11.

(Document marked as Defendant's Exhibit No. 11.)

BY MR. BLAKE:

Q. What has just been handed to you has

been marked as Defendant's Exhibit 11 which I'll represent to you is a copy of your expert report along with Exhibits A and B which are your CV and bibliography that were produced or disclosed at the same time as your report. Have you seen this document before?

A. Yes.

Q. And let me just clarify because when I started referencing this document, you reached for the other documents that are in front of you. Those documents in front of you are a selection of exhibits which have already been produced during depositions in this case. We may refer to some or all of them during the course of the deposition. I just wanted to put those in front of you so you had them handy if we go back to them.

A. I understand.

Q. Okay. And we were talking about your rate of compensation. If you would go to Page 2 of your report, Paragraph 6, you've indicated what you're being compensated for in this case; is that accurate?

A. Yes.

Q. And you can leaf through this exhibit

briefly, if you would like, and, you know, just to confirm, this is a true and accurate copy of your report, your CV and your bibliography, noting the amendments or extra items added at the beginning of the deposition by your counsel.

A. There's a slight addition to No. 11.

Q. Paragraph 11?

A. Correct.

Q. On Page 3?

A. Yes.

Q. Okay.

A. I've also lectured in South America.

Q. Very good. Anything else?

A. The rest is accurate as it is.

Q. If you go to the front page of the report, look at Paragraph 4, you state that the materials you considered in forming your opinions are listed in Exhibit B or referenced in the report. Do you see that?

A. Yes.

Q. Let's just briefly turn to Exhibit B for the moment. It's nine pages from the back or something like that. Exhibit B is the bibliography. Let me know when you're there.

A. I'm there.

Q. Okay. You've listed approximately 50 or so different books and articles and publications in this bibliography, is that about right?

A. Approximately.

Q. And some of these items were written by you, right?

A. Yes.

Q. Others were written by different people, correct?

A. Correct.

Q. Now, I know you said in Paragraph 4 that the materials you considered in forming your opinions were listed in Exhibit B, but you didn't review all of these materials like in preparation of this report, right?

A. Correct.

Q. These are materials that represent some of the items that you reviewed or digested I suppose over the course of your career studying transgender and gender issues, right?

A. These are the primary sources that inform my opinions in the whole area of gender incongruity and gender diversity.

Q. If you were going to put together a course of study on those issues, this would be a nice library of information, right?

A. Depending on the course.

Q. Depending on the course?

A. I might pick and choose some other materials that I have in my library at my office.

Q. Okay. And these aren't the only materials that you have studied in your career, right?

A. Correct.

Q. You've obviously studied probably a whole bunch of other documents, books, articles in the field of general psychology and PTSD and the areas of expertise that we talked about, right?

A. Absolutely.

Q. Okay. If you turn to Page 2 of the bibliography, there are four items towards the top that you've listed that you've authored or co-authored, do you see those?

A. I do.

Q. Why these four?

A. Specifically the books that I've authored?

Q. Yeah. Why did you identify -- Well, are these the only items that you have written related to gender or gender identity, transgender issues?

A. No.

Q. So why did you identify specifically these four in this bibliography?

A. Gender Loving Care, the first one, contains, beginning on Page 30 of that book, the narrative of the attempts to change a person's gender identity and the futility of those changes or those attempts which is referenced in my report when I discuss the history of the -- our understanding of the etiology of gender dysphoria.

The second one listed here, "Secrecy and the Pathophysiology of Hypertension" is referred to in this report when I discuss how fear of revealing a private issue, what my gender identity is and what I've done to change my anatomy, causes an increase in the risk of hypertension to the extent of a hundred percent.

Q. Okay.

A. The third is a textbook written by Italian colleagues in which I contribute a lengthy

and very descriptive chapter on the brain differences and the etiology of what we then call transsexualism, what we now call gender dysphoria.

And the fourth is a chapter that I co-authored with my colleague in Madrid who actually has done the functional magnetic resonance imaging studies and we collaborated on producing that chapter and incorporating those brain studies in that very recent work which is a textbook used in medical and surgical curricula. That is why those four are listed.

Q. Okay. You said the terminology for transsexualism has changed to gender dysphoria; is that right?

A. Correct. We moved away from the term transsexual.

Q. But those are -- Well, when did that change occur approximately?

A. It's not a -- there's no sort of literal, but the term has been abandoned because it conflates transgender and sexuality which are unfortunately often conflated by people and further increases misunderstanding about this misunderstood area of human behavior.

Q. Okay. But I guess for the purposes of things you've written, if you have written something and you refer to transsexualism, that also means gender dysphoria? They are synonyms?

A. Severe gender dysphoria and transsexual are synonyms, although you won't see the word transsexual like in the DSM-5, for instance.

Q. They use --

A. Gender dysphoria.

Q. Or in the DSM-4 they use something else, right?

A. Gender identity disorder which is a different -- it's not just a change in the nomenclature.

Q. Oh, it's actually a --

A. There's a conceptual difference.

Q. It's a different diagnosis?

A. They're conceptually different. It's not just a change in the name.

Q. Does the DSM-5 contain both?

A. No.

Q. Okay. Do you know what the reason for the change was?

A. I do.

Q. Go ahead.

A. The change was brought about by our evolving understanding that people's identities are not disordered, which was what was implied in gender identity disorder, which would mean that that was a permanent condition, someone's identity is disordered.

Rather, gender dysphoria in the DSM-5 is characterized as a medical condition which has attendant psychiatric problems which usually ensue from social problems that are created and accompany the diagnosis, but the criteria is the distress that a person experiences and so that is why the change occurred.

Q. Okay. I'll pretend I understand that for now. It seems very nuanced to say the least.

A. The change also occurred in the World Health Organization and how they characterized gender dysphoria.

Q. Okay. Of the items that you've identified in your bibliography, did you review any of them specifically in relation to your retention as an expert in this case?

MS. INGELHART: Objection, vague, but you

can answer.
BY THE WITNESS:
A. I would look through them if you'll give me permission.
BY MR. BLAKE:
Q. Sure. Yeah. I asked the question.
A. Yes, I reviewed the DSM-5 which is on Page 1. And if you're asking specifically for this deposition, Principles of Transgender Medicine and Surgery, the second edition.
Q. Sorry. Which one is that?
A. That's on Page 2.
Q. Let me see if I can find that one.
A. It's under Ettner.
Q. Oh, got it. That's the MRI study one, right?
A. That's part of what is contained in that book. It's a textbook that contains --
Q. A lot of material?
A. -- a lot of material.
Q. All right. So before we move onto the next one, what in -- Well, actually let's just finish what you're doing and we'll go through each of those.

A. I'm done. Those are the only things I really looked at prior to the deposition.

Q. Perfect. With the DSM-5, what parts of that did you review?

A. I reviewed the footnote, I think it's on Page 457, that talks about the heritability and the genetic -- potential genetic components of the condition that the DSM-5 was beginning to acknowledge in 2013 when it was published.

Q. Okay. To your knowledge, has a genetic component been identified?

A. There have been several studies which have -- and you can see if we turn again to this bibliography, Hare, H-a-r-e, is one researcher who that has found a genetic allele that is associated with gender dysphoria in individuals who are assigned male at birth but are female. That group, Hare, et al, have isolated an allele.

And there is another study listed here where they've also, I believe it's Australian researchers, who -- Let's see. Which study is it? Yes, Bentz, the Bentz Group on Page 1. They have found a gene -- just in layman's terms I'm going to -- I'm not a geneticist, so I don't -- I have

only a very broad understanding of the alleles involved here, but it's related to sex steroid metabolism but only in those individuals who are assigned female at birth and have a male gender identity.

Q. So there's some studies that suggest a potential genetic --

A. Correct.

Q. -- component of transgender individuals, but you're not a geneticist, right?

A. Those are the twin studies which indirectly implicate genetics because twins have a high concordance for gender dysphoria, and that's what's alluded to in the DSM-5.

Q. So the DSM-5's reference --

A. Is to the twins studies.

Q. It's 2013. It comes after the Bentz study, but to your knowledge, the DSM-5 doesn't incorporate the Bentz "A Polymorphism of the CYP17 Gene Study," right?

A. Not specifically. The twin studies have been replicated over and over by many different researchers, most significantly Milton Diamond who's done the largest studies, but others such as

Gomez-Gil have noted that the likelihood of someone having -- someone who's transgender having a sibling who's transgender is five times that of the general population which implicates a genetic component to the condition.

Q. That's the conclusion of Diamond?

A. No, that's the conclusion of other researchers, Richard Green and Gomez-Gil. So there's been many studies along these lines by different groups throughout the world.

Q. So the DSM when it references the potential for genetic component --

A. As a footnote.

Q. -- as a footnote, your understanding is that that is in reference to the 2013 Diamond study regarding the transsexuality among twins which you've referenced on Page 2?

A. And other investigators. I don't think it mentions Diamond per se, but there's an assemblage of research on twins.

Q. I'm looking at --

A. Diamond studies.

Q. -- the bottom of Page 2, there's a Gomez-Gil.

A. Gomez-Gil, yes.
Q. "Familiarity of Gender Identity Disorder in Non-Twin Siblings," is that the one you're referring to?
A. That's one of the groups that has done that work. Also Richard Green did that work as well.
Q. On Page 3, Richard Green, "Family Co-Occurrence of Gender Dysphoria: Ten siblings of Parent-Child Pairs." Those are the ones?
A. Those are the ones I've listed, uh-huh.
Q. Those are the ones that --
A. I'm most familiar with.
Q. -- that you're most familiar with?
A. Yes.
Q. And probably based on the date of publication for the DSM-5, the Gomez-Gil and the Green studies would have been available at the time of publication, right?
A. Oh, yes.
Q. The Diamond study, it's hard to tell, but they appear to have been published in the same year as the DSM so maybe less so the Diamond study, but certainly Gomez-Gil and Green were available,

right?

A. And there is -- As I say, there are many researchers who have done similar studies, but I'm less familiar with those studies than I am -- I know Milton Diamond. Many of these people are my colleagues.

Q. Did you -- You didn't provide an expert opinion on whether or not gender dysphoria has a genetic basis, right?

A. I have provided that expert opinion.

Q. In this case did you provide an opinion that gender dysphoria has a genetic basis?

A. Not a genetic basis. Neurobiological basis is how I think I would phrase it.

Q. Because you're not a --

A. Geneticist.

Q. You're not a geneticist, right?

A. Correct.

Q. All right. Other than the DSM and the Principles of Transgender Medicine and Surgery, did you review any other materials in preparing your report in this matter?

A. Yes.

Q. Before we get into that, what parts of

the Principles of Transgender Medicine and Surgery did you review?

A. The first chapter.

Q. What does that relate to?

A. Theories of the etiology of gender dysphoria.

Q. Is that the chapter that you authored?

A. With a colleague, co-authored.

Q. And what is etiology?

A. Origin.

Q. Specifically how was the origin of transgenderism relevant to your opinion?

A. It's relevant because given that gender dysphoria is caused by an interaction of hormones and the developing brain, it's immutable.

Q. Okay. So that chapter, the first chapter of Principles of Transgender Medicine and Surgery relates to your conclusion that gender identity is immutable?

A. Correct.

Q. All right. What other materials did you review?

A. I reviewed, in addition to my expert report, the report of Dr. Nick Gorton. I reviewed

the complaint in this case. I reviewed a report by the defendant's expert.

Q. Dr. Van Meter?

A. Yes. And the rebuttal addendum, and I reviewed the judge's opinion.

Q. Did you review any of plaintiffs' discovery responses?

A. No.

Q. Did you conduct any interviews of any of the plaintiffs?

A. No.

Q. And in your review of the Gorton expert report, the Van Meter report, the complaint and the judge's opinion, did you take any notes?

A. No.

Q. Have you ever met any of the plaintiffs in this matter?

A. No.

Q. So I take it you haven't conducted any medical or psychological examinations of the plaintiffs?

A. I have not.

Q. Did counsel for plaintiffs provide you with any other materials besides the things that

you've listed today?

A. No.

Q. Since rendering your written opinion which is now marked as Defendant's Exhibit 11, have you reviewed any additional materials in connection with this matter?

A. Since rendering this opinion?

Q. Yes.

A. Yes.

Q. Okay. What else have you reviewed?

A. Dr. Gorton's report and all of the other -- with the exception of the complaint, all of the other documents that I previously listed.

Q. Now I understand. Chronologically that obviously makes sense. Before you rendered your opinion, you looked at the complaint?

A. Correct.

Q. And the items in the bibliography we just discussed. After your report, Dr. Van Meter's report, you received that; Dr. Gorton's report, you received that; and obviously the judge's recent opinion, you received that, right?

A. Yes.

Q. Okay. Anything else?

A. No.

Q. Okay. And just to make sure that the record is clear, you haven't spoken to anyone else other than counsel in connection with this matter since rendering your opinion; is that accurate?

A. Yes.

Q. All right. Let's go to Exhibit A to your report which is your CV. I'm not interested in replowing a lot of the same ground that we've already covered, and I don't anticipate spending a long time on your CV, but just a few kind of basic questions.

Is your CV still true and accurate?

A. Yes. There's one addition, one minor addition.

Q. Okay.

A. A presentation that I gave that's not listed here.

Q. All right. Which one is that?

A. It's the presentation I gave in Miami of this year to the American Academy of Plastic Surgeons.

Q. Okay. Of course they would meet in Miami. The deponent is shaking her head yes.

A. They met in the summer in Miami.
Q. Well, it's always Miami.
What was the title of that presentation?
A. "The Transgender Patient."
Q. And I take it that that presentation was mostly dedicated to the specific procedures that plastic surgeons are involved in when someone is doing their gender affirmation surgery, right?
A. Yes.
Q. That makes sense.
Just looking at the top block of information here, positions held and I guess clinical and professional experience, together that forms I think what we can loosely call your employment experience, right?
A. Yes.
Q. You've never worked as a medical doctor, right?
A. Pardon me?
Q. You have never worked as a medical doctor?
A. I am not a medical doctor.
Q. And like you said before, you don't have

any expertise as a molecular geneticist, right?
A. Correct.
Q. And you don't have any experience as an endocrinologist, right?
A. I have experience with endocrinology. I am not an endocrinologist.
Q. Right. Your husband is, right?
A. No.
Q. No, he's not?
A. No.
Q. I'm sorry. You're married, right?
A. Yes.
Q. Okay. I just noticed that your --
A. My husband is a primary care physician.
Q. Ahh, he's a primary care physician. You had written an article with him, right?
A. Yes.
Q. Okay. I just -- I guess I misunderstood when I looked him up what his job was. Fair enough.
So he's not an endocrinologist either, right?
A. No.
Q. We talked before about your areas of

specialty within the field of psychology. Do any of those areas have like a special certification or a license that you obtained?

A. I have a certification from WPATH. I'm certified as a WPATH provider which is a new or relatively new certification program that they've undertaken, and I have been designated as a fellow and diplomat in the clinical evaluation and trauma and post-traumatic stress disorder as mentioned previously.

Q. WPATH is the World Professional Association of Transgender Healthcare, right?

A. Correct.

Q. And I see this fellow and diplomate in trauma/PTSD listed under positions held. I don't see the WPATH provider listed.

A. It says Global Education Initiative Committee.

Q. Okay. That's the --

A. I have been grandfathered into the certification program and was one of the founding educators in that program.

Q. So the Global Education Initiative Committee is morphed into the WPATH provider

certification?

A. The Global Education Initiative Committee is an attempt to educate providers throughout the world about providing care to transgender patients, and there's coursework. We teach courses to endocrinologists, surgeons, nurses, physical therapists, lawyers, people who work with, military people, who work with transgender individuals.

And ultimately if they take all of the coursework, pass a test and get supervision, they can receive a certificate that they are a certified WPATH provider.

Q. Okay. And so you are one of the instructors?

A. Correct.

Q. You obviously have received a certificate?

A. Yes.

Q. The certificate is issued by this committee --

A. By the organization.

Q. And the organization is WPATH?

A. Yes.

Q. Okay. And you had a hand or a part in shaping the curriculum for the committee?

A. Yes. Yes, that's correct.

Q. Okay. Who else -- How many members are on the committee?

A. On the actual committee?

Q. Yes.

A. Let me count on my fingers now.

Q. Okay.

A. Ten people serve on the committee, and there are other people who have often trained. So we have someone training now, for instance, in Kazakhstan, but there are ten people that actually are on the committee, meet monthly, update the curriculum and the slides, and some are mentors, et cetera, et cetera.

Q. Who is responsible for selecting the curriculum for this WPATH provider certification?

A. Specialists in each particular area.

Q. Are they all committee members?

A. I would say they are, although at times we might ask someone else to weigh in.

So, for instance, our colleagues in Europe do not have the same hormone preparations

that we have here in the U.S., so if we're giving a talk in Amsterdam, we might ask them what the generic name for a specific pharmaceutical product that we get here is. They are not a member of the committee, but they are an expert in endocrinology and a WPATH member.

Q. Got it. Does the WPATH provider certification, is that recognized by the APA?

A. The APA recognizes the WPATH guidelines which are the standards of care and endorses them, as do many other organizations, and so GEI is based on our standards of care.

Q. What is a GEI?

A. This Global Education Initiative that we teach is based on the standards of care which has been translated into 15 languages and informs care throughout the world.

Q. All right. So WPATH has created a standard of care and APA has, I don't know what the word you use, approved -- what was the word you used?

A. Endorsed, as has World Health Organization, the American Psychiatric Association, American Academy of Family Physicians, National

Committee on Correctional Healthcare, American College of Plastic Surgeons, et cetera, et cetera, et cetera, many organizations, National Association of Social Workers.

All of the major medical organizations adopt and follow and encourage individuals to follow the guidelines that the standards of care provide which are promulgated by WPATH.

Q. When we say standards of care, just so the record is clear, we're talking about standards of care for transgender individuals, right?

A. Transgender, gender nonconforming, yes, and --

Q. The host of gender identity issues?

A. Correct. And we're talking now about the 7th iteration of the standards of care.

Q. And the GEI, the Global Education Initiative Committee, based its WPATH provider curriculum on the standards of care?

A. Correct.

Q. Okay. But the APA hasn't specifically endorsed the curriculum that the Global Education Initiative Committee came up with, correct?

A. I don't know that they have or have not. They do give credit for it. The APA gives credit for it. They give CE credits for it, and they attend our core courses.

Q. As a psychologist, like a lot of professional careers, you're required to maintain some amount of continuing education after you get your degree?

A. Correct. So you would get CME credit if you're a medical provider, CE credit if you are -- et cetera.

Q. The classes that WPATH puts on as part of this initiative count towards whatever the annual or bi-annual requirement is?

A. That's correct.

Q. Okay. But you're not aware one way or the other whether the APA says, yeah, we recognize that as a certificate that would say make you an expert on providing care to transgender individuals?

A. Well, they do because the person who makes that determination has met with our executive director. I'm not privy to those exact conversations, but, yes, and on that basis they

grant CE credit.

Q. All right. There's not any sort of like APA guideline or statement saying, you know, WPATH provider is a certification we recognize and endorse?

A. There is a statement by the APA that does talk about WPATH and the standards of care, but I believe that the Global Education Initiative is new enough that they've not issued a statement about that in particular.

Q. All right. I understand. Thank you for that clarification.

Professional affiliations on Page 8 of your CV, if you could turn there and let me know when you're there.

A. I'm there.

Q. Are these still current?

A. To the best of my knowledge. I may not have paid my dues for the Scientific Study of Sexuality, but I believe that I'm current.

Q. Better get on that.

I don't want to divulge or diverge, I don't know, I don't want to divulge or diverge into, you know, some, I don't know, frolic, about

why are you a member of the Screenwriters and Actors Guild?

A. Because I frequently -- in the past, I frequently appeared on television.

Q. Oh, okay. That's fun.

And so you just joined SAG, right, it's called for shorthand SAG in order to --

A. Receive payment for those appearances.

Q. Is that part of like you're required if you are going to be on television you have to join it?

A. No. No. But if you want to get paid, you have to be a member.

Q. Is it like a union thing?

A. That's a good question. Off the record?

Q. I will tell you what, we are on the record. Let's not go off the record to talk about this.

A. Okay.

Q. It's funny. You know, I'm interested. It's just kind of -- it's an interesting thing, right?

A. Well, I don't know if it's a union or

not so I don't -- I guess it is. I mean, they give insurance to people and I pay dues and I used to get royalties.

Q. That's fun. Sorry. I was curious.

The World Professional Association for Transgender Health, you've got that listed here as one of your professional affiliations. That's the WPATH that we have just been talking about, right?

A. Correct.

Q. To your knowledge, are there any qualifications to be a member of that organization?

A. Yes.

Q. What are the qualifications?

A. You have to have a license from a professional organization. You have to demonstrate that you have been working in the field for a certain amount of years. I'm not quite sure what the other ones are. You have to sign onto our mission statement, and you can apply to be a student member if you're a student, but you must be a professional who can demonstrate that you belong to a discipline and are licensed by that discipline and work with this population.

Q. So any professional organization? Like I mean, for example, could a lawyer?

A. Yes, we have a legal committee.

Q. What about teachers?

A. We don't have teachers per se. We have sexologists or sex educators.

Q. From your description, it doesn't sound like a teacher would be prohibited from joining. They receive a license, and they, I assume, work with transgender students, you know, high school students or middle school students, elementary school students.

A. I don't know.

Q. You don't know?

A. I don't know if we have teachers. I mean, we have people who are like professors who teach at a, you know, advanced higher education.

Q. But they are sociologists or something, right?

A. Right. Most of our members are either mental health professionals, surgeons, physicians or people in related fields such as voice and communications.

Q. Okay. So it's not an organization that

anyone could just go online, pay the fee and join?

A. Correct. I mean, these are -- it's an international organization and it also has chapters throughout the world, so we have an EPATH which is just European members. There's --

Q. APATH? Don't know?

A. There is a Latin American. You know, there's different chapters throughout the world.

Q. LAPATH?

A. There's a USPATH.

Q. USPATH?

A. Which is strictly United States members.

Q. Okay. And it's interdisciplinary?

A. Interdisciplinary.

Q. Okay.

A. We say multi disciplinary.

Q. Why?

A. Because providing optimal care to the transgender population typically involves multidisciplinary care.

Q. Okay. Are you an officer with the World Professional Association For Transgender Health?

A. Yes.

Q. What is your position?

A. I'm the secretary.
Q. What about the USPATH --
A. No.
Q. Okay. Are you affiliated with the USPATH?
A. By virtue of being a member of WPATH, I'm a member of USPATH.
Q. The World Professional Association For Transgender Health is an advocacy group, right?
A. No.
Q. It's not?
A. It is not.
Q. You don't consider what WPATH does to be an advocacy group or advocacy work?
A. We consider WPATH to be a professional association.
Q. Okay. Would you consider at least an element of what they do to be advocacy?
A. I can speak for myself in that I'm advocating for a condition which I believe is the most misunderstood condition in human behavior, but I'm not advocating for an individual. I'm advocating for education about the condition.
But I imagine there are people who

advocate who are members of the organization, but we are a professional organization and there are other organizations that are made up of community members that are advocacy organizations, but we consider ourselves a professional organization that publishes the standards of care and that provide services to an underserved population.

Q. You wouldn't consider one of the WPATH's missions to be advocacy?

MS. INGELHART: Objection, asked and answered and vague. You can answer.

BY THE WITNESS:

A. Advocacy -- we advocate for human rights, yes, but, I mean, I wouldn't characterize WPATH as an advocacy organization.

MS. INGELHART: Can we go off the record for a second?

(WHEREUPON, discussion was had off the record.)

(Whereupon, a short break in the proceedings was taken.)

MS. INGELHART: Just for the record, our witness here wants to clear up something that she thinks might be a misunderstanding or

misconception.

MR. BLAKE: Okay.

THE WITNESS: I may have left you with the impression that only endocrinologists provide hormones, and that is not accurate. Any physician who's knowledgeable and experienced can provide hormones to transgender patients.

So primary care physicians do that, and they are all members of our organization, so it's not just endocrinologists. It can be internists, primary care people like my husband. There are obstetricians and gynecologists who do that as well. So one needn't be an endocrinologist.

BY MR. BLAKE:

Q. Understood. I didn't get that impression from you.

A. Okay. I thought I might have given that impression.

Q. No, but thank you for the clarification.

Psychologists can't prescribe or administer hormones, right?

A. Right.

MR. BLAKE: This is going to be

Defendant's Exhibit 12.

(Document marked as Defendant's Exhibit No. 12.)

BY MR. BLAKE:

Q. You've just been handed what has been marked as Defendant's Exhibit 12, and based on your exclamation, I assume you recognize this document?

A. Yes.

Q. What is it?

A. It's the 7th iteration of the standards of care published by the World Professional Association of Transgender Health.

Q. And this is the most recent version of the standards of care?

A. Yes, although we are presently working on Version 8.

Q. All right. Do you have a hand in authoring these standards?

A. I am one of the authors of the standards of care.

Q. And in general do you agree with everything that's in the standards of care?

MS. INGELHART: Object, vague in scope and possibly speculation, but you can answer to the

best of your ability.
BY THE WITNESS:
A. I endorse the standards of care. The rationale for revising the standards of care is that certain aspects of this may be a little behind the times or they may need to be refined based on our current cultural and research.
BY MR. BLAKE:
Q. I think I understand.
A. In general though, yes, I subscribe and I support the standards of care.
Q. There's a Version 8 coming out and presumably Version 8 is going to modify in some respect Version 7?
A. Correct.
Q. To the extent that Version 8 is modifying Version 7, you have a different understanding now and that's in the process of being flushed out, right?
A. Most of the changes will be modest. There's not going to be any major changes.
Q. When do you anticipate that volume, Volume 8, being published?
A. Not before next year, 2020.

Q. Sometime in 2020?
A. We hope to debut it at our next international symposium in November of 2020, but that may be wishful thinking.
Q. So maybe not even in 2020 at all, it could be 2021?
A. I imagine it will be 2020.
Q. Okay. If you would turn to Page 31 of this document, let me know when you're there.
A. Are these pages numbered?
Q. On the bottom right-hand corner there are page numbers.
A. I see it. Okay.
Q. At the very bottom, you'll see a caption that says other tasks of mental health professionals. Do you see that?
A. On the bottom of Page 31?
Q. Yes.
A. Yes.
Q. Okay. And the first numeral says, "educate and advocate on behalf of clients within their community, schools, workplaces, other organizations and assist clients with making changes in identity documents." Do you see that?

A. Uh-huh.
Q. So one of the standards of care or one of the directives of the standard of care is to have mental health professionals advocate on behalf of transgender individuals to help them change their identity documents, right?
MS. INGELHART: Objection, vague. You can answer.
BY THE WITNESS:
A. That's what it says, yes.
BY MR. BLAKE:
Q. You can put that aside for a minute.
You are also affiliated obviously with the American Psychological Association?
A. I'm a member, yes.
Q. And it's fair to say that not just anyone can be a member of the American Psychological Association, right?
A. Correct.
Q. In fact, you need a Ph.D. in psychology to join, right?
A. That I don't know.
Q. Do you know if you have a masters degree, is that enough to be a full member of the

American Psychological Association?

A. I don't know.

Q. So unlike the WPATH, to your knowledge a much narrower group of people can be part of the APA, right?

A. I don't know what the requirements for membership are.

Q. Lawyers can join the APA, sorry, or the WPATH, right?

A. Yes.

Q. To your knowledge, can a lawyer join the American Psychological Association?

A. I don't know.

Q. You don't know one way or the other?

A. I don't know one way or the other.

Q. We're going to back up in your CV just a few pages. You have a list of presentations that starts on Page 2 and that carries on into publications starting on Page 5 and ending all the way on Page 8. Do you see that?

A. Yes.

Q. Not all of these are relevant to the opinions expressed in your expert report, right?

A. Not all my publications are relevant to

this report, correct.

Q. And the same goes for all of your presentations, not all of those are relevant to your expert report, right?

A. Correct.

Q. This may be difficult, but are any of these presentations or publications especially relevant or more relevant than others?

A. I suppose.

Q. I suppose the better question would be which of these publications or presentations are the most relevant in your mind?

A. Beginning with presentations?

Q. Yes, please.

A. Well, starting with "Mental Health Issues in Transgender Healthcare" which is on Page 2.

Q. Yep.

A. That's a lecture I give to students, and I would regard that as relevant because I talk about the impact of minority stress and discrimination and victimization, the impact that it has on individuals, and I go into quite a bit of depth on that topic.

Q. Okay.

A. Turning the page, "Sticks and Stones: Childhood Bullying Experiences," I consider that relevant because I talk there about the harms of when individuals are singled out and particularly the impact it has on the brain, the architecture of the brain which is a relatively new area of research.

"Gender Identity and the Standards of Care," well, I mean, we've touched on that and I think that's relevant only in a tangential way. It mentions -- the standards of care do mention that having congruent identity documents attenuates gender dysphoria. Let's see.

Q. So far we're batting nearly a thousand.

A. In the American College of Legal and Legal Medicine Presentation, a colleague of mine who is an attorney and who's also a trans man talked about discrimination and the harms that occur when people who look like he does, for instance, he's bald and has a full beard and he's 70, would have to, for example, use a female bathroom, how that would be a totally untenable situation.

Q. So you're talking about "Transitioning: Bathrooms are Only the Beginning?"

A. Correct, the American College of Legal Medicine.

Q. Again that one is focused on the harmful impacts that you would describe as discriminatory laws or policies towards transgender people?

A. Yes, and the harms that ensue.

Q. Okay.

A. I think, you know, if you look at the bottom of the page, the Global Education Initiative, all of our -- a good deal of the slides that we show and the presentations that we offer have to do with minority stress, barriers to care, discrimination in certain settings, et cetera, et cetera.

"Gender Affirming Psychotherapy," "Adult Development and Quality of Life in Transgender Healthcare," this was for the National Institute of Child Health and Human Development, NIH, and, of course, when we talk about quality of life, part of our mission there was to talk about expanding a research strategy to eliminate discrimination and barriers to care, particularly

healthcare, to improve the overall healthcare of transgender people in the U.S.

Q. So that's the "Adult Development and Quality of Life?"

A. Yes. "Care for Transgender Inmates," I mean, you know, supporting transgender students, what are we talking about? Allowing them to live in their affirmed gender, treating them with the same respect that all other students are treated, et cetera, et cetera. And we actually go into the statistics about how most students, the first act of discrimination that they experience is in school.

"Understanding Transgender," I would say that part and parcel of these presentations, the majority of them, except for Page 5 I would say that none of the presentations on Page 5 are relevant at all to the issues we're discussing today.

Q. Publications, any of these very or more relevant to your expert opinion than others?

A. Well, I would say that the Theories of the Etiology of Gender Identity as we've already talked about.

Q. Right, that's one that you have --

A. The Ettner publications. Walter Bockting, who specializes in stigma, and that's the Bockting, Coleman, Deutsch. Bockting has written extensively on stigma, and Sevelius, J. Sevelius has talked about stigma and discrimination as a predictor of HIV in transgender patients, so that might be considered relevant.

We have talked about the pathophysiology of hypertension as a result of fear of discrimination and fear of violation of privacy.

White and Ettner looked at how stigma impacts children and the impact of having a parent who transitions.

Q. That is the "Adaptation and Adjustment in Children of Transsexual Parents?"

A. Correct. And then again disclosure risk and protective factors in children, so children often like to keep it a secret because they are afraid that they will be discriminated against or stigmatized if they have a parent who's transgender, so we go into some detail about that.

Of course, Gender Loving Care: A

Guide to Counseling Gender Varying Clients talks at great length about the challenges that transgender people face.

And I think that that's, you know, by and large the relevance of those.

Q. Any of these presentations or publications which you've identified from your CV, do any of them discuss the immutable nature of gender identity?

A. Yes.

Q. Which ones?

A. "Etiology of Gender Dysphoria."

Q. That's a writing?

A. That's on Page 5. That's a publication.

Q. Publication on Page 5?

A. Yes. "Theories of the Etiology of Gender Identity" on Page 6; "Principles of Transgender Medicine and Surgery." "The Adult and Development of Quality of Life" which that was presented at the National Institute of Health.

And Guillamon, who you see is an author there, was invited here from Spain by the National Institute to discuss the brain differences in transgender people which obviously we can't

change people's brains, so that would be directly implicated.

And then in Management of Gender Identity Dysphoria, "Etiopathogenetic Genetic Hypothesis on Transsexualism." On Page 7, "The Etiology of Transsexualism" in 2007, and then that book was revised in 2016, and I think that about concludes that topic.

Q. And then same question but from a biologic basis for transgenderism, which presentations and/or publications address that issue?

A. Which of these publications?

Q. Yes.

MS. INGELHART: Objection, vague and possibly speculation, possibly. You can answer.

BY THE WITNESS:

A. So I would say that in addition to the publications that I've authored, the publications that I've referenced also are an important component of that, so let me start with that.

BY MR. BLAKE:

Q. Well, why don't we answer my question?

A. Okay.

Q. Your publications.
A. My publications.
Q. Yes. That deal with the biologic basis, if any.
MS. INGELHART: Objection. Just like in our prior depositions with the clients, there's -- I would like to object to terms that could be terms of art are at issue in this case, so biological may be one of those terms. Thank you.
THE WITNESS: Right. I don't know that I would use the term biological as opposed to social as a lay person kind of distinction. I mean, we wouldn't say biological. We would say, you know, neurocortical or neurophysiologic, but whatever. Let's keep it simple.
BY MR. BLAKE:
Q. If you look at Page 6 of your expert report, Paragraph 25, you say, "a growing assemblage of research documents that gender identity" --
A. "Is immutable."
Q. "And biologically based."
A. Uh-huh.
Q. So I already asked you about the

immutable, publications that deal with the immutable issue. Now I'm trying to understand which of your publications address this biologically based issue, which that's a term that you've used. I'm not using it as a term of art. I'm using it however you used it in Paragraph 25.

A. Would you like me to start with my publications?

Q. I would.

A. In Gender Loving Care -- Oh, no, wait. We'll start at the beginning.

On Page 5, "The Etiology of Gender Dysphoria" in 2017 will have a lengthy discussion about precisely that issue, including the very areas of the brain that are different, the microstructure, the volume, the areas of the right hemisphere and the thickness of the cortical thickness.

In 2016 Ettner and Guillamon in Principles of Transgender Medicine and Surgery will have an addition to all of the early theories. It will have all of that research that was available as of 2016, digit ratio research, the genetic research, the twin studies, the family studies, the

functional magnetic resonance studies, the sexually dimorphic areas of the brain, the Zhou article on the -- really one of the first that was done by autopsy, it will have all of that information in that publication.

In the Guillamon, in the next "Current Opinion in Endocrinology and Diabetes," some of that will be repeated in there. In the 2015 "Etiopathic Hypothesis on Transsexualism," that will have some, slightly less because it's an earlier work, but the 2017 -- the 2016 will have -- and 2017 will have more of the latest information, although there's more since then which a simple literature review would reveal.

Q. When you say 2016 and 2017, what are you referring to?

A. 2016 is when we revised the 2007 Principles of Transgender Medicine and Surgery.

Q. So there's a 2016 version of that?

A. Yes.

Q. Okay.

A. Because the book was originally -- the edited volume was published in 2007. By 2016 there had been so much more information that we were

asked by the publishers to revise it, which we did, and changed one of the editors.

Q. Understood.

So the "Etiology of Transsexualism" in Principles of Transgender Medicine and Surgery has a 2016 edition that you say has the most current -- more current information than the 2007 version?

A. More current.

Q. Then the Principles of Transgender Medicine and Surgery also from 2007 has a 2017 version?

A. No, 2016.

Q. Okay.

A. 2017 refers to Page 5, Gender Confirmation Surgery: Principles and Techniques, "The Etiology of Gender Dysphoria." That was written for a surgical atlas.

Q. Are those all?

A. That's all that's from my publications.

Q. And you have referenced a number of times the work done by, hopefully I don't butcher this name, Guillamon.

A. Antonio Guillamon.

Q. Guillamon who worked with brain studies. Is that the MRI imaging of the brain?

A. FMRI.

Q. FMRI.

A. He also does work with some genetic work as well.

Q. Is he a neurologist?

A. He's a neuropsychologist.

Q. He's a neuropsychologist. Is that outside your field of expertise?

A. Yes and no. As a psychologist, it's an area of specialization, so I don't specialize in that area, but I have some understanding of it, and so I went to his lab and collaborated with him.

MS. INGELHART: Can we go off the record really quick?

(WHEREUPON, discussion was had off the record.)

BY MR. BLAKE:

Q. So you said your area of specialization is not in neuropsychology?

A. Correct.

Q. You have some understanding of the field, right?

A. Yes.
Q. You've read the literature, some of the literature at least, correct?
A. Yes. And my research partner, Dr. Tanya White, is a -- also does magnetic -- brain imaging in the Netherlands.
Q. To the extent that you've written about that topic, has it always been in partnership with someone who has expertise or specialization in neuropsychology?
A. To the extent that I have published their results, yes, it has always been in collaboration with them.
Q. And is your expert opinion in this case in any way -- Strike that.
Are you offering an expert opinion in this case based on some analysis or understanding of neuropsychology?
MS. INGELHART: Objection, vague. You can answer.
BY THE WITNESS:
A. No.
BY MR. BLAKE:
Q. And you wouldn't consider yourself an

expert in that field, right?

A. Correct.

Q. I assume you are familiar with the term neuroplasticity?

A. Yes.

Q. Do you know to what degree any of those studies considered or controlled for neuroplasticity?

A. The studies that were done in Spain are studies that look at the effect of sex steroids on the brain which is not related to neuroplasticity.

Q. So it's your understanding that the Guillamon studies are not -- would not be impacted by concerns over neuroplasticity or anything like that?

A. That's not what they're looking at.

Q. They're not looking at the change of a brain over time, just over the course of someone's life, they're looking at what specific input does to a brain; is that accurate?

A. Well, they're looking at many things. I mean, there's an entire laboratory of individuals, not just Dr. Guillamon, who do this work, and one of the things that they're looking at is the impact

of sex steroids on the brain.

So they look at the brain prior to an introduction of sex steroids, and they look at the brain post, and they look at it over a period of time, and they look at the differences in certain areas, and they do topography, and they do many other different kinds of studies, but they look at the areas of the brain that in, for example, people who are assigned male at birth but have a female gender identity, they look at the areas of the brain which are sexually dimorphic and whether they are masculine, demasculinized, feminine, and what those -- not just those areas, but the microstructure, the volume of certain areas and the cortical thickness which varies across adult life.

So I'm happy to talk more about this. This gets very complicated.

Q. I'm sure it does.

A. I'm happy to go as far as you would like me to go with this.

Q. Not too much further I hope.

A. Previously this could only be done on autopsy where we could actually slice the brain.

With functional magnetic resonance imaginary, we can look at adult living people over time and it allows us to have an unlimited amount of brain images, whereas, with autopsy --

Q. You get one?

A. Yeah. You get one dead one and you can't ask them questions.

Q. It doesn't change over time, right?

A. And also you don't know if what you're looking at is an artifact of hormonal use, so did the hormonal use cause the change in the brain or was the change in the brain there prior to hormonal use which is something that we can actually see now.

There are also steroid studies that have to do with smell, but that's extremely complicated, and I'm going to leave that for another day.

Q. Yeah, I don't --

A. You don't want to go there.

Q. I didn't see olfactory as one of the potential indicators.

A. But it is a sexually dimorphic defining characteristic, but it's extremely complex to even

talk about if you're not, you know, a scientist.

Q. Sure. Let me ask you this about the Guillamon studies. Those all involved transgender individuals, right?

A. The particular study that I think we're focusing on here, because again this group of individuals are researchers, they conduct research all the time. They haven't done just one study.

Q. Not just on transgender individuals, they're studying all sorts of aspects of the brain?

A. They are studying all sorts of brain aspects. They're working with people in Ghent, Belgium who are doing genetic work. So there's a lot of work going on in this field.

There's an Austrian researcher who's also doing brain work which I'm less familiar with because Antonio is -- you know, I've become a colleague of his.

Q. Sure.

A. This particular research did imaging of brains of people prior to starting hormones and looked at people who had been assigned male at birth, and I have all of these images at home on power points. I don't have them with me.

But you can see -- in some of the slides, you can see the areas of the brain that differ, and we know, like if you look at the bibliography, that there are various parts of the brain, initially we thought it was just the BSTc that was sexually dimorphic, but we know now that I think it's the INAH and there are all sorts of areas.

So if you look at the -- you know, I'm sorry to do this to you.

Q. What page are on?

A. I'm on Page 4 now.

Q. Of the bibliography?

A. Yes. If you look at the middle of the page where it says Schneider, "Typical Female 2nd-4th Finger Length (2D:4D) Ratios in Male-to-Female Transsexual-Possible Implications For Prenatal Androgen Exposure," there's a wealth of information about this 2D:4D digit length, and in infants that died prior to birth, when they've looked at it, they've already seen this ratio, so we know this is something that has do with prenatal hormones because it's present prior to birth.

So there's a wealth of research. If

you look at the Rametti/Carillo, he studies the microstructure of the brain, the white matter of the brain. So there's a lot of components of the brain and cortical thickness is a big one.

But what's important for people like me to know is that most of the differences are in the right hemisphere of the brain which is significant to psychologists because that's the area of the brain that has to do with somatic perception.

Q. Can you tell me what that is?

A. I'll leave it there.

Q. Why is that relevant?

A. Because it's lunchtime.

That's relevant because that is the part of the brain that has to do with how we perceive bodies, our own bodies, other bodies, our perception of our bodies, our perception of other people's bodies, the link between certain areas of the brain.

So that is a very significant area of the brain, that right hemisphere, and that's where most of the differences occur in people who are gender dysphoric and non-gender dysphoric.

They talk about four different brain phenotypes, a non-transgender female, a transgender female brain, a non-transgender male brain and a transgender male brain. So you see four different brain phenotypes on functional magnetic resonance imaging. Class dismissed.

Q. Just to kind of finish up this line of questioning. I think you answered my question about who was part of the Guillamon study. And then I take it they did the MRI imaging pre you were calling it sex steroids. I assume that's hormones?

A. Hormones, correct.

Q. So they looked at the transgender person prior to their receipt of hormones?

A. Correct.

Q. And then after their receipt of hormones, there was some significance to what happened to some region of the brain?

A. Well, what they're --

Q. Is that study -- Is that sort of the very, very stupid litigator version of what the study showed?

A. No.

MS. INGELHART: Yeah, objection, misstates prior testimony, mischaracterizes.

BY MR. BLAKE:

Q. Please.

A. Yes. No. What they found -- So I have to back up a bit. On autopsy when Zhou in the year 2000, Z-h-o-u, in the Netherlands found on autopsy that people who were transsexual had a different brain structure than people who weren't, the New York Times heralded that and said what transsexuals have been saying all along is true, that their brain is female, you know.

Then the criticism arose. Well, how do you know that those changes weren't caused by the hormones.

Q. Right.

A. And that's what these studies showed, that the changes were there prior to the hormone.

Q. Understood.

A. So that my brain has -- areas of my brain are all feminized. The sexually dimorphic brain, the parts that are sexually dimorphic on MRI would all be feminized.

A transgender woman's, you would see

that certain parts of her brain, even though she was assigned male at birth, are likewise feminized, and that's before she's had any interventions. So that's what was significant.

There was also some similar research done in someone who found that the number of neurons was larger in one area of the brain, and someone said well, maybe that was a result of hormones and then they went back and did a similar study, and they said no, we've counted the neurons, you know, so...

Q. I think I understand. I do.

A. I think you do.

Q. I think I do now that you put it in those simple terms.

It's your understanding that neuroplasticity does not -- isn't relevant though to the study conducted by Guillamon?

A. Guillamon, yes. Neuroplasticity refers to the brain's ability to grow and change and to develop new neurons. That would be not relevant to the volume of brain matter or the BSTc area of the hypothalamus -- the structure of the BSTc of the hypothalamus.

It would have to do with a person's ability to learn new materials and grow and certain areas taking over from other areas if there's a deficit, so it's an important concept, but it's not what this particular study set out to look for, nor would it change the findings because the findings seem to be consistent throughout research across the world.

And a large review of all of this is available in the Archives of Sexual Behavior. They did a review of all of this research.

Q. Okay. I think I understand your position on it. I think we can take a break.

MS. INGELHART: Great.

(WHEREUPON, a lunch break was taken.)

MR. BLAKE: Back on the record.

BY MR. BLAKE:

Q. Let's look back at Exhibit 11 which is your expert report and Page 2 of the export report, Paragraph 5. Let me know when you're there.

A. You know, I'm going to get my glasses. Did you say Paragraph 5?

Q. 5, yes.

A. Yes.
Q. And that lists several cases which over the last four years you've testified as an expert at trial or by deposition, right?
A. Correct.
Q. Okay. Broussard v. First Tower Loan. That's the first case you've listed there, do you see that?
A. Yes.
Q. Was that a case that involved transgender individuals?
A. Yes.
Q. What was the issue in that case?
A. This was a case concerning a young man who applied for a job and he was a trans man and he was in his first week of work and doing exceptionally well, and his boss was very pleased with him, and she asked to see an identity document of his.

He showed her an identity document, and it had a marker that was female, although he was living as a man and he had a beard, et cetera, and she wasn't concerned, but she told her manager who traveled what do I do about this, you know,

we've hired this man and he's doing beautifully, but his license says female, and his manager said that he was female and would have to comply with the female dress code.

Well, of course, he couldn't do that. You know, he wasn't about to show up in a dress anymore than you would come here in a dress or whatever their female dress code was, so he had to leave that position, and that was the grounds for a lawsuit against the employer.

Q. That was an employment discrimination case?

A. Yes.

Q. Okay.

A. I guess that's what it would be.

Q. Did any of these cases have anything to do with requiring the state to update, change or correct any identity documents?

A. Well, I don't know what the ultimate -- I know that case went to a higher court, so I don't know what the ultimate resolution of that was. I think there may have been some -- I don't know. I know that it became a much bigger course -- a much bigger case than I was aware of, and so I really

can't say what the -- it started with an identity document. I don't know where it ended up.

Q. Did any of these cases -- Did your expert testimony in any of these cases involve requiring or requesting the state to make a change or correction to an identity document?

A. No, not that -- not with my involvement.

Q. And then that case that was mentioned at the outset, which is in addition to these Monroe v. Jeffries, did that case -- did your testimony in that case involve a request to the state to change, modify, correct an identity document?

A. That wasn't what I was asked to opine about, although there was -- an issue was raised because prisoners are not allowed in the state to have their names changed.

Q. That case, Monroe vs. Jeffries, involved a name change?

A. I don't know. It was mentioned because the prisoners were not allowed to have a name change while incarcerated, and it was a class action suit against the State of Illinois.

Q. Okay. If you go to Paragraph 8, which is the bottom of Page 2 and carries over to Page 3,

it says that you've evaluated or you state that you've evaluated 2,500 to 3,000 individuals with gender dysphoria, right?

A. Yes.

Q. Does that constitute all of the transgender individuals who you have worked with?

A. It's now in excess of 3,000.

Q. Okay. Does every transgender individual receive a diagnosis of gender dysphoria?

A. No.

Q. So how many transgender individuals have you evaluated over the course of your career approximately?

A. Over 3,000.

Q. So is it -- I guess I'm trying to understand. You evaluated between 2,500 and 3,000. Like most of those people receive a diagnosis of gender dysphoria, but not all; is that accurate?

MS. INGELHART: Objection, vague. You can answer.

BY THE WITNESS:

A. Not every transgender individual receives a diagnosis of gender dysphoria.

BY MR. BLAKE:

Q. Okay. And not every transgender individual who comes to see you receives -- you don't diagnose every transgender individual with a diagnosis of gender dysphoria, right?

A. Correct.

Q. Have you ever evaluated someone who is transgender whose gender identity later reverts back to their birth sex?

MS. INGELHART: Objection to the term at issue, birth sex, as well as these others that we have discussed. But answer to the best of your ability.

BY THE WITNESS:

A. I have evaluated I think on two occasions people who have attempted to reverse their surgery or have regretted having the surgery, and one I think attempted to revert to living in their birth sex but they didn't -- they did not state that their gender identity had changed, just that they needed to live as a man for a variety of other reasons.

BY MR. BLAKE:

Q. All right. Are you aware, just in the

profession, of transgender folks who have -- whose gender identity has reverted to their birth sex?

A. I am aware of people who have detransitioned.

Q. Is that the terminology, detransitioned?

A. Detransition means they have reverted to living in the sex they were assigned to. It doesn't necessarily mean that their gender identity has changed, and I wouldn't know without actually interviewing or assessing those people.

Q. So have you ever assessed an individual who has detransitioned whose gender identity has, I suppose, I mean, reverted is the word we've been using. Are you comfortable with that word? I'm not trying -- again, I'm not trying to be tricky. She objected to birth sex. You've used natal sex.

A. No, I have never used natal sex.

Q. You've never used natal sex, okay.

A. I use sex assigned at birth.

Q. Sex assigned at birth. You've never diagnosed or, I don't know, worked with a transgender individual whose gender identity has reverted to their sex assigned at birth; is that accurate?

MS. INGELHART: Objection. I think vague and mischaracterizes prior testimony, but please answer to the best of your ability.

BY THE WITNESS:

A. I'm aware that some people who have transitioned from the sex they were assigned at birth have reverted to living in the gender, the sex they were assigned at birth. I cannot state that their gender identity has changed, only that the circumstances under which they live have changed.

Q. Okay. And then in the literature and in your experience in the industry and things that you've read about transgender individuals, are you aware of any instances where a person's gender identity has reverted back to their birth sex or sex assigned at birth?

A. Young children often show gender nonconforming behavior or a separate condition called gender identity disorder in childhood, and prior to Tanner's Stage 2 or prior to preadolescence, it's unclear whether or not those children will have a gender identity that differs from the gender identity they were assigned at

birth.

So with children, one can't really know -- even if they show gender nonconforming behavior, one can't make a determination that they're transgender until they reach an older -- later stage of development.

So those children may very well appear -- you know, parents may worry my child is playing with dolls, my child is going to be transgender and that may not be the case, so with children that's not uncommon.

Q. So with children there may be some indicia that their gender identity does not confirm to their sex assigned at birth, but over time, you know, that gender identity becomes more settled for that particular individual, does that occur?

A. It will crystalize at some point closer to adolescence or preadolescence at Tanner Stage 2 when secondary sex characteristics emerge.

Q. So as the child reaches adolescence, their gender identity tends to crystalize?

A. Yes.

Q. But you're not aware of that ever happening with an adult who for a period of time

gender identifies, you know, or has incongruent gender identity with their sex assigned at birth and then whose gender identity later reverts back to their birth sex?

A. No. Again their lived experience, they may live in the sex they were assigned at birth for a variety of reasons, but I don't know that they would say that their gender identity -- no one has ever told me that their general gender identity has changed.

Q. And you've never read any literature about that occurring?

A. Not literature that I'm aware of or that is well known to me.

Q. Okay. Let's go to Paragraph 15. It's on Page 4 of your report. I'm going to read the first sentence.

It says, "medical management of gender dysphoria includes the alignment of appearance, presentation, expression and often the body to reflect a person's true sex as determined by their gender identity." Do you see that?

A. I do.

Q. What do you mean by a person's true

sex?

A. The gender that they experience as their authentic and affirmed gender regardless of that which they were assigned at birth.

Q. Is the sex determined by their chromosomes their true sex?

A. No.

Q. Is the sex determined by their natural hormone levels their true sex?

A. Not solely, no.

Q. Is the sex determined by their external genitalia their true sex?

A. No. Not entirely, no.

Q. Is the sex determined by their internal reproductive organs their true sex?

A. No, not necessarily.

Q. In your expert opinion, does anything other than the gender identity have any role to play in the identification of a person's true sex?

A. Sex is a composite of many components. Some are visible and some are nonvisible. For most people, the visible components of sex are concordant with their gender identity and their sense of what category they belong to.

For a transgender person, that isn't true, and gender identity for people is the most paramount component in that category.

Q. What scientific basis do you have to support your opinion that a person's true sex is most paramountly determined by their gender identity?

A. The fact that identity is the major component of the self system and people who are gender dysphoric, severely gender dysphoric, if they can't change and modify their behavior -- their bodies, rather, they will -- in my experience, we see the natural course of this condition in the prison where people are not allowed to initiate a gender transition, and we see one of three trajectories; complete psychological decompensation, auto castration or auto penectomy or suicide.

Q. What about for those transgendered who are not severely gender dysphoric?

A. If they're gender dysphoric, they will seek treatment. If treatment is not available, as it wasn't in the past, we saw an inordinately large number of suicides amongst people who were

untreated for gender dysphoria.

Q. What about for the transgender individuals who are not gender dysphoric, is gender identity the most paramount component of what you described, the composite?

A. If they are transgender but they don't have the diagnosis of gender dysphoria, they don't have the clinical distress, they will express the aspect of their affirmed gender when it's safe, convenient and possible for them to do so. So identity is the most important and the most enduring aspect of personality.

By analogy, a study was done on Alzheimer's patients. They had lost all cognition. They didn't know who their children were. They couldn't speak. They had absolutely no cognition left at all. And yet when nurses spoke to them in baby talk, they got very agitated because they retained the identity of an adult.

So identity is the most persevering, nothing outpaces it, nothing outruns it, and identity, as Erickson says, is really the organizing principle of self and personality.

Q. So it's your testimony then that gender

identity, regardless of whether or not a transgender individual is diagnosed with gender dysphoria, gender identity is the most important component of a person's sex?

A. That's not my opinion. My opinion is that for people who experience gender dysphoria, for those people whose assigned sex at birth doesn't comport with their gender identity, and they experience significant distress about that, they will go to great lengths, including performing surgery on themselves, in order to bring the gender identity and the body into alignment. That's my opinion.

Q. Okay. So if you go to the next page, Page 5, Paragraph 21. You wrote, "when there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation." Do you see that?

A. Yes.

Q. All right. Does that statement apply for all transgender people?

A. Yes. All transgender people who by definition experience an incongruity will have the

need to affirm to a certain degree the gender identity with which they define themselves.

For some people, that may be appearing in their affirmed gender when they are not at work, as often as they can, in social situations. For other people who have more severe -- a more severe form of that condition and actually meet the criteria for diagnosing them with gender dysphoria, they will require medical and often surgical interventions.

Q. So it's true then that for a transgender person, their gender identity is the primary determinant of their sex designation in your opinion, right?

A. Yes. If they are adults, yes.

Q. Okay. If they are adult. Setting aside the children?

A. Yes. Yes.

Q. Would you say the same thing is true for cisgendered folks as well?

A. I would say yes, that identity overall is the most important part of the self system.

Q. It's just the other side of the coin, right?

A. Well, people whose anatomy is in accordance with their gender identity --

Q. It's easy for them?

A. -- they don't give it any thought. It's a nonissue. But identity is what makes you you.

Q. It may not be a nonissue, just cisgendered people don't spend a whole lot of time thinking about it I would guess?

A. If any time thinking about it.

Q. Have you ever looked at an Ohio birth certificate?

A. No.

Q. If you look in the stack of documents I gave you at the outset, if you look at Exhibit 1, which I'm happy to provide you, this is an Ohio birth certificate. It happens to be the birth certificate for one of the plaintiffs in this case.

The word gender doesn't appear on the birth certificate, right?

A. Correct.

Q. At least according to this document, what Ohio tracks and records is a person's sex, right?

A. Yes.
Q. Is it your understanding that that record is made at or near the time of birth?
A. Yes.
Q. Do you have any opinion on whether or not the State has value in recording an individual's sex at birth?
MS. INGELHART: Objection, calls for speculation and legal conclusion. You can answer.
BY THE WITNESS:
A. I don't have any opinion about that.
BY MR. BLAKE:
Q. You don't have an opinion one way or the other?
A. I mean, I believe that it's common in that it's important to have some vital statistics on our citizens.
Q. I mean, like, for example, the way in which information is compiled on birth weight for a particular sex, right?
A. Correct.
Q. When a person is born, do you have a general understanding of how the sex of that individual is determined?

A. Yes.
Q. What is that understanding?
A. A cursory examination of the external genitalia.
Q. When you say cursory, do you think there should be a more extensive review of a person's genitalia before a medical provider determines male or female?
MS. INGELHART: Objection, calls for speculation. You can answer.
BY THE WITNESS:
A. Well, I've been at many births and I've seen where a midwife will see the external genitalia and will announce the birth of the -- the sex of the child based on that.
BY MR. BLAKE:
Q. And in your opinion that's cursory. You said cursory.
A. Right. It's based on a physical of how the genitals appear at the time of birth. There's no internal exam done. There's no ultrasound done. It's just a look and see.
Q. Do you have an expert opinion on whether or not it would be appropriate for a medical

provider to do a more extensive examination of the anatomy of the newborn to determine male or female?

A. Not at the time of birth.

Q. Because you used the word cursory, I was wondering if you had any idea as to whether or not they need to do more.

A. No, there's nothing more that can be done other than to glance at it unless there's some ambiguity about it at birth, and then there would be a more extensive visual examination done with later followup attention.

Q. So even though you describe what generally happens at birth as cursory, you nevertheless admit, I mean, that's appropriate as well, at the time of birth, right?

A. Correct.

Q. And you obviously recognize that the concept of sex at birth is different from a person's gender identity, right?

A. Yes. Sex assigned at birth.

Q. Sex assigned at birth, sure.

A. Yes.

MR. BLAKE: We'll do Exhibit 13.

(Document marked as Defendant's Exhibit No. 13.)

BY MR. BLAKE:

Q. I've just handed you what has been marked as Defendant's 13 which is an article titled "Transsexual Couples, Qualitative Evaluation of Atypical Partner Preferences" written by Randi Ettner Ph.D. Is that you?

A. Yes.

Q. So the very first sentence says transsexualism. That's that old term that is no longer in use anymore?

A. Correct.

Q. But we understand is synonymous with gender dysphoria?

A. Yes.

Q. Okay. "Transsexualism, the condition whereby one desires to change one's natal sex, has always been a part of the human experience." Do you see that?

A. Yes.

Q. All right. So before when we talked briefly about natal sex, you had said that that wasn't a term that you had used.

A. That I hadn't used today.
Q. Oh, okay. Not ever in the history of your writing.
A. Historically we used to talk -- we used to use natal sex or some people would say genetic sex, and we have moved away from that.
Q. But those are terms that we use or I bring it up in your writing, you understand what that means, right?
A. Yes, assigned at birth, the sex assigned at birth.
Q. So it's a terminology difference?
A. Correct.
Q. You say sex assigned at birth. Previously that was referred to in some circumstances as natal sex, other times genetic sex, but those are synonymous, if antiquated; is that accurate?
A. Genetic sex I don't think was something that was ever really a term that professionals used, but we did use natal sex.
Q. All right. You can put that one aside for now.
A. It was a good article.

Q. I did read it. I mean, since you brought it up, genetic sex on the second -- on the second page of the document, the middle paragraph on the left-hand column, the paragraph that begins "in one instance," let me know when you get there. Are you there?

A. What section?

Q. Second page of Defendant's Exhibit 13.

MS. INGELHART: It's the third page.

BY MR. BLAKE:

Q. Sorry, it's the third page, left-hand column, and there's a paragraph in the middle which starts "in one instance." Do you see that paragraph?

A. Uh-huh.

Q. And then the second to last sentence says, "following surgeries, one individual left the relationship stating that her preference had shifted and she desired a relationship with a genetic male." Do you see that?

A. Yes, because the community members do use the term GG, genetic girl or genetic male, but it was not a term that professionals preferred to use, so here I'm talking about somebody else's use

of the term.

Q. It's not necessarily a medical or scientifically defined term, but it has a meaning just sort of anecdotally?

A. Right, and people would say so and so is a GG meaning a genetic girl. Community members might say that.

Q. Is it accurate when someone says a genetic male or GM or genetic girl or GG, they're referring to the phenotypes that we know, you know, XX and XY?

A. Those aren't phenotypes.

Q. Okay. Karyotypes, sorry. Not phenotypes, karyotypes.

A. Yes. But I have to say that I haven't heard those terms used. I don't know how old this article is.

Q. It looks like 2007.

A. No, it looks like that's when it was published.

Q. You might have written it prior to that?

A. It would have been -- Yeah, it was probably written like in 2005 or so.

Q. All right.

A. We don't -- I think even the community wouldn't use those terms any longer.

Q. But at one point in time?

A. Yes. Yes.

Q. Like we said, genetic male, that would imply what we were talking about as a karyotype?

A. A non-transgender person or what's sometimes referred to now as cisgender.

Q. Okay. So a transsexual person, a transgender person, that's someone who, and I think you said this earlier, whose gender identity doesn't conform to their sex assigned at birth or natal sex as you used in that one article, right?

A. Someone who has gender incongruity, yes.

Q. Someone who has gender incongruity.

And that can lead to and often does lead to a desire to change their natal sex, right?

A. It leads to a desire to transition.

Q. Transition from their natal sex?

A. From the sex they were assigned at birth to their affirmed gender.

Q. That gender incongruent individual does not desire to change their gender identity, right?

A. Their gender identity doesn't change,

but the way they live and the way they appear publicly is what needs to change so that they are regarded by others and by themselves as the gender that they believe is their accurate and affirmed identity.

Q. It's their gender identity which is actually giving rise in part to their desire to change their natal sex or, as you call it, the sex assigned at birth, right?

A. I believe that's right. Would you say that again?

Q. Yeah. It's their gender identity which is giving rise to their desire to change their natal sex or as you call it the sex assigned at birth, right?

A. It's the incongruity.

Q. Between their gender identity?

A. Yes, and the sex they were assigned at birth.

Q. A cisgendered person's gender identity isn't going to want them to change their natal sex obviously?

A. Correct.

Q. If you look at Paragraph 16 of your

report, that's Defendant's Exhibit 11, on Page 5. Let me know when you're there.

MS. INGELHART: I'm sorry. What paragraph?

BY MR. BLAKE:

Q. Paragraph 16 on Page 5.

A. Yes.

Q. "For a transgender person, a birth certificate bearing an incorrect gender marker invades privacy, releases confidential medical information and places the individual at risk for grave psychological and physical harm." Do you see that?

A. Yes.

Q. When does the sex identifier on a transgender person's birth certificate become inaccurate?

MS. INGELHART: Objection to these terms again, but go ahead.

BY THE WITNESS:

A. I don't understand the question. I'm sorry.

BY MR. BLAKE:

Q. Well, you wrote in Paragraph 16 that a

birth certificate bearing an incorrect gender marker invades privacy. I'm asking you when in your opinion that sex identifier on the birth certificate becomes incorrect.

A. When it conflicts with the person's lived experience and their gender presentation.

Q. It's not your opinion that a medical provider should have recorded a different sex based on the medical information available at the time of birth, right?

A. That is not my opinion.

Q. Because there's no way to determine whether a person is transgender at the time of birth, right?

A. Correct.

Q. I'm going to read you a sentence and I want you to tell me whether you agree with that sentence or not, all right?

A. Yes.

Q. There's no test, medical or psychological, to diagnose transsexualism. Would you agree with that sentence?

A. Yes.

Q. In fact, it's common for transgender

individuals to present at age 60 or older, right?

MS. INGELHART: Objection, vague. You can answer.

BY THE WITNESS:

A. Present? I'm not certain what --

BY MR. BLAKE:

Q. Sure.

A. To present for treatment?

MR. BLAKE: This is going to be 14.

(Document marked as Defendant's Exhibit No. 14.)

BY MR. BLAKE:

Q. I've just handed you what has been marked as Defendant's 14 which is an article entitled "Psychological and Social Adjustment in Older Transsexual People" written or co-authored by Randi Ettner. That's you, right?

A. Yes.

Q. You recognize this article?

A. I do.

Q. If you turn to the second page of this article, the first full paragraph begins, "In contemporary western societies, it is not unusual for transgender individuals to present to a

clinician at age 60 or older." Do you see that?

A. Yes.

Q. Okay. So you would agree that at least for a period of time the sex identifier for these individuals on their birth certificate is accurate, right?

A. No.

Q. So for the first 60 years of these people's lives, they live as one sex?

A. Yes.

Q. All right. And then at age 60 or older, they present to a clinician, right?

A. Yes.

Q. And those individuals are I suppose diagnosed with maybe some sort of gender incongruity, right?

A. Yes.

Q. And it's your testimony that in all those individuals, that gender incongruity was always present or present for a majority of their life?

MS. INGELHART: Objection, compound. You can answer.

BY THE WITNESS:

A. The gender identity was present. For many individuals, they didn't have the language or the understanding that this was a condition, that there was resources for transition or they had other reasons to delay transition, financial reasons, medical reasons, whatever.

Their gender identity hasn't changed, but the transition begins late in life. Also, if you read the article in its entirety, gender dysphoria intensifies with age, so it's actually quite common for people in mid life to say I've always felt different, I've always felt like I should have been a girl, I got married, et cetera, et cetera, but I can't go on like this any longer. The gender dysphoria actually intensifies with age.

BY MR. BLAKE:

Q. So it's your testimony that you believe that every one of these individuals who present to a clinician at age 60 or older, that their gender identity, when it crystalized, you know, back in adolescence or pre-adolescence, their gender identity was from that point fixed in stone and the next 40 or so years of their life, they just

were -- they just didn't know; is that accurate?

A. I can't speak about what any given group of individuals knows or when they personally had the language, had the ability, the understanding to determine that they had this condition.

What I can say is they live in the sex that they were assigned at birth until later in life, and at the point where they transitioned and requested new identity documents, if they, in fact, did transition, then those identity documents should reflect their new lived experience.

So I'm not commenting on what age they crystalized their gender identity, but when they transitioned, they would require documents to match their new presentation and their life in their lived gender.

Q. So it's possible that these individuals had a gender identity which conformed to their sex assigned at birth for a large portion of their life, maybe even most of their life, but at some point obviously it changed, right?

A. I wouldn't make that statement. What I would say is it's possible that an individual lived their life according to society's expectations

never knowing that there existed an opportunity to change until they saw it on a television show or they saw Christine Jorgensen and they said, oh, that's what I've been feeling, I never knew there was a name for my pain.

So people, particularly people in the prison from resource poor backgrounds, many of them are in prison in their later -- at age 30 or 40, they learn that there is a condition and that they're not the only person in the world who feels this way, and prior to that they were just living in the body they were born with and trying to live in accordance with a sex they were assigned at birth regardless of any discomfort they may have felt.

Q. On that same page of this exhibit, Defendant's Exhibit 14, do you see a little chart just a few paragraphs below that first sentence we just read? Do you see that chart?

A. Those arrows?

Q. Yeah, the arrows. And you say in the sentence just above the arrows, "three forces converge in late adulthood to provoke personal crisis in the elderly transsexual; social, identity

and hormonal," right?

A. Uh-huh.

Q. Do those social factors have an impact on someone's gender identity?

A. No. They have an impact on somebody's desire to transition.

Q. Do the biological forces have an impact on someone's gender identity?

A. They intensify dysphoria.

Q. But do they have an impact on someone's gender identity?

A. Not on identity per se but on gender dysphoria, on the severity and some of the attendant psychological symptomatology. Anxiety and depression and feelings of hopelessness, suicidality, et cetera can intensify with age when cortisol increases, as it does for all humans with age.

Q. Does the third factor there, identity, have an impact on a person's gender identity?

A. With aging, what we know developmentally, as people become more concerned with their mortality, people will say if I don't do this now, when will I do this.

So we saw that after 9/11 people who have been gender dysphoric said I could die tomorrow. I need to do this now. I can't put it off any longer.

Q. So I guess I didn't hear an answer to the question.

Does the force of identity in late adulthood impact that elderly person's gender identity?

A. Identity in the sense that Erickson, the Ericksonian concept of identity versus integrity. In other words, how do I live my life in accordance with my values and what do I believe and that increases, those feelings increase as mortality becomes closer in one's experience.

Q. You differentiate between your usage of identity in this paragraph and someone's gender identity?

A. This is not gender identity.

Q. Okay.

A. This is identity.

Q. On the last page of this, you already somewhat referenced this quote under No. 2, discussion, that third paragraph. Let me know when

you're there.

A. Yes.

Q. It says, "individuals who present to clinicians at middle age should be made aware that gender issues often intensify with age." Do you see that?

A. Uh-huh.

Q. By gender issues, do you mean gender identity intensifies with age?

A. Dysphoria.

Q. You didn't say dysphoria. You said issues.

A. Right. Issues around incongruence, how will I live my life, shall I transition, issues that involve gender identity and how my experience of who I am and how I live in the world will intensify, and this is something that I see quite commonly in the people I treat.

Q. When you use the word gender issues, that includes gender identity, right?

A. It includes anything having to do with this idea that I'm not in the body I belong in and yet if I change this body, will I be allowed to see my grandchildren. That's an issue that people

deal with when they consider transitions at a later age.

Q. That includes issues of gender identity, right?

A. Yes.

Q. Back to your expert report. Same page, Page 5, Paragraph 17.

A. Yes.

Q. Let me know when you're there.

A. I'm there.

Q. Okay. "At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate and your birth assigned sex matches that person's actual sex; however, for transgender people, the sex assigned at birth does not align with the individual's genuine experienced sex resulting in the distressing condition of gender dysphoria." Do you see that?

A. Yes.

Q. When you say a person's actual sex, you mean that as defined by their gender identity, right?

A. Yes.

Q. And when you say that infants are assigned a sex typically male or female, you're referring that in most -- you're referring to that in most cases the sex assigned at birth is binary, right?

A. What I'm referring to is that the primary sex characteristic, which is external genitalia, determines which category an infant is assigned to.

Q. That's boy or girl, right?

A. Correct. In most cases, yes.

Q. In most cases?

A. Yes.

Q. Let's set aside the cases where people have some abnormality to their external genitalia.

A. Okay.

Q. You're not rendering an opinion regarding that, right?

A. Correct.

Q. Okay. And is it your understanding that none of the plaintiffs have alleged that they have any of those conditions?

A. I'm not aware of that.

Q. Okay. So that boy or girl distinction, that's a binary choice, right?

A. Choice?

Q. Well, it's binary, right? I mean, boy, girl.

A. They are assigned to one category or another.

Q. By definition one or the other, binary, right?

A. Yes.

Q. And that's the binary choice that is generally reflected on Ohio's birth certificates, right?

A. Yes.

Q. You would agree with me that gender is not binary, right?

A. Yes.

Q. And would you agree with me that the WPATH standard of care warns against imposing a binary view of gender on transgender individuals?

A. I don't understand the question. I'm sorry. Could you rephrase it?

Q. Yeah. Do you agree that the WPATH standard of care, which you helped author,

discourages mental health professionals from imposing a binary view of gender on transgender individuals?

MS. INGELHART: I was just going to say objection, foundation. If you could show her that to refresh her memory.

MR. BLAKE: I'm asking whether she agrees with that. I'm not asking her whether she said that.

BY THE WITNESS:

A. I think you're asking what WPATH thinks, and I don't know what all of the individuals in WPATH think. I know there are individuals who would say they are transitioning from one gender to another; whereas, there are individuals who may say I just want to demasculinize.

BY MR. BLAKE:

Q. All right. Let's look at Defendant's No. 12. Objection sustained. I'm trying to short circuit this. We can go to the source text.

Go to Page 16 of the standards of care which is Defendant's 12. Are you there?

A. Yes.

Q. Bullet No. 4 says, "mental health

professionals should not impose a binary view of gender." Do you see that?

A. Yes.

Q. Do you agree with that statement?

A. Yes.

Q. So despite the WPATH standard of care which warns against imposing a binary view of gender on transgender individuals, it's your expert opinion that the State of Ohio should nevertheless impose a binary expression of plaintiff's gender identity on their birth certificates, right?

MS. INGELHART: Objection, calls for a legal conclusion and speculation. You can answer.

BY THE WITNESS:

A. I don't understand the question. I'm sorry.

BY MR. BLAKE:

Q. Well, it's your opinion that Ohio birth certificates should be changed -- their sex identifier on Ohio birth certificates should be changed to match someone's gender identity, right?

MS. INGELHART: Objection, calls for a legal conclusion, but you can answer.

BY THE WITNESS:

A. My opinion is that if a person undergoes a gender transition, their identity documents should be amended to reflect their lived experience.

BY MR. BLAKE:

Q. That's binary, that M or F on the birth certificate is binary, right?

MS. INGELHART: Objection, compound, and I think speculative and possibly asking for a legal conclusion, but you can answer.

BY THE WITNESS:

A. I don't know if it's possible to put an undifferentiated, anything other than an M or F, on a birth certificate, but it is my opinion that if someone requests to have their identity documents changed and they have them -- and they request that they're changed from an M to an F because they now are living as a female and that would comport with their lived experience, then it is my opinion that the identity document should be amended to reflect that.

BY MR. BLAKE:

Q. Even if it does impose a binary view of their gender identity?

A. I don't think it imposes a binary view. I think it reflects a person's gender identity transition.

Q. In a binary expression, right?

A. In that case, yes. My interpretation of the standards of care is that mental health professionals should not impose their view that because someone talks about feeling unlike a man or unlike a woman that that mental health professional should encourage them to transition or to have medical or surgical interventions, that they shouldn't impose some binary or predictive because the standards of care go on to say that the patient should be allowed to express their gender rather than have the mental health professional impose that on them.

Q. And that's because, I think you would agree, that gender is more appropriately conceptualized as a continuum rather than two distinct categories, right?

A. That's my belief, yes.

Q. And you also believe that the binary male/female classification system fails miserably in addressing the disposition of the minority group

of individuals who fit into a category inconsistent with their natal assignment, right?

MS. INGELHART: Object. If you want to show her a document to refresh her recollection that you seem to be reading from.

BY MR. BLAKE:

Q. Do you agree with that statement?

A. I don't know if I do or not. I would have to look at it carefully and reflect on it.

Q. I'm not going to use this as an exhibit because this is my only copy, but what I'm holding is Confessions of a Gender Defender, a book -- a quite lovely book actually written by Randi Ettner, Ph.D. I assume you're familiar with this text?

A. Yes.

Q. And on Page 128, I'll let you look at this after I'm done, but it says, "in truth, gender is more appropriately conceptualized as a continuum rather than two distinct categories." That's what it says.

It goes onto say -- Let's see if I can find that exact quote. I didn't want to mark it up either. "No one is totally masculine, nor totally feminine; therefore, this binary

classification system fails miserably in addressing the disposition for the minority group of individuals who fit into a category inconsistent with their natal assignment or into no category at all."

You still agree with that statement, right?

A. Yes.

Q. If you want to take a look at it.

A. No, I agree with that.

Q. Okay. We talked briefly before about the outdated and perhaps less than scientific use of the terms genetic male and genetic female. Do you recall that testimony?

A. Yes.

Q. Genetic male, we may have talked about this, but that would be someone who has an XY karyotype, right?

A. I'm sorry, repeat that.

Q. Genetic male would imply that the person has an XY karyotype, absent some abnormality, chromosomal or otherwise?

MS. INGELHART: Objection, speculation. You can answer.

BY THE WITNESS:

A. That's what is typical; however, we can never know what a person's genotype is without karyotyping.

BY MR. BLAKE:

Q. Understood. But in the normal case, absent some deviation from what the norm would be, genetic male is likely going to have an XY genotype?

A. Likely, yes, I agree.

Q. I don't want to quibble over the percentages of irregularities because I've never had my karyotype tested, have you?

A. No. It's almost unheard of in the United States. It's expensive and it's not done.

Q. All right. Nevertheless, in the normal case, someone's karyotype will normally dictate the sex organs that they are born with, right?

A. It's one component of the phenotypic development of the primary sex characteristics at birth.

Q. Okay. And the same -- you would say the same thing for someone's external genitalia, when

those develop normally --

A. The genitalia is the primary sex characteristics and the others are the secondary sex characteristics.

Q. Understood. Back to your report, still Page 5, Paragraph 18 now. That says, "external genitalia alone, the critical criterion for assigning sex at birth, is not an accurate proxy for a person's sex." Do you see that?

A. Yes.

Q. You would say though that external genitalia are an accurate proxy for a person's karyotype, right?

A. No.

Q. So in the normal case, without, you know, any abnormality with external genitalia, a normal phenotype, a normal genotype, lots of types, if you had an external genitalia of male, wouldn't that be a good indicator that they have XY chromosomes?

A. A good indicator?

Q. Sure.

A. It's a likely indicator.

Q. Likely?

A. Not necessarily though.
Q. Understood, but in most cases it's going to be an accurate proxy for that person's chromosomes?
A. In most cases.
Q. Excluding the abnormalities that we --
A. Can't see.
Q. -- that we can't see. All right. As far as you know aren't at issue in this case, right?
A. As far as I know.
Q. And would you agree that most people's chromosomes are consistent with the physical appearance of their external genitalia?
MS. INGELHART: Objection, calls for speculation. Again like to these -- I hope we can agree we've had like a standing objection on the use of these terms of art that are at issue, but you can answer.
BY MR. BLAKE:
Q. That's fine. Would you agree with that?
A. Would you repeat the question?
Q. Yeah. That most people's chromosomes

are consistent with the physical appearance of their external genitalia, I mean, other physical attributes.

A. There are many chromosomal anomalies where genitalia can appear normal, however, there is a chromosomal anomaly, so a person could, for instance, have two Xs and a Y and have a normal appearing genitalia, and we'll assume for the sake of this conversation that the majority of people have a primary sex characteristic or an external genitalia. The majority of those people will have a normal chromosomal pattern.

Q. Consistent with the outward physical appearance?

A. The majority of people, right.

Q. Whether it's 70 percent or 95 percent or 99.9 percent, the normal --

A. Very often we're just not aware of the anomalies. Without karyotyping, we don't know.

Q. I think this is what you just stated, but in the normal sense of it, right, most people, their external genitalia then would be an accurate proxy for whether a person is a genetic male or genetic female, right?

A. For most people who are assigned a sex at birth, based on their genitalia, that is an accurate reflection of their gender identity and they are comfortable with that assigned sex.

Q. For those who aren't assigned sex at birth, it's because there's some ambiguity or maybe they're born with intersex conditions because those individuals --

A. Or gender identity.

Q. Well, no one is born with gender identity. I mean, we already talked about how you can't identify gender identity at the time of birth, right?

A. That doesn't mean they're not born with it. It's within the brain. It's just they don't express it.

Q. Got it. I wasn't talking about gender identity.

A. Okay.

Q. I was talking about genetic male, genetic female which we previously -- you know, those are old terms, those are archaic terms, I get that. We're talking about external genitalia and their correspondence to genetic maleness or genetic

femaleness. For most people, it's an accurate --

A. It's concordant for most people.

Q. Let's go to Paragraph 19 in your opinion, Page 5 still. Are you there?

A. Yes.

Q. All right. In that paragraph you identify five components that comprise a person's sex, right?

A. I have to count them.

Q. It's always a good idea to check a lawyer's math. Yes?

A. Yes, I mention five.

Q. All right. Perfect. Chromosomal composition, right?

A. Yes.

Q. That's the XY and the XY karyotyping we have been talking about, right?

A. Yes, and the other types which --

Q. Sure.

A. -- could be present, right.

Q. XXX, XXY, whatever, right?

A. There's at least 35 of them.

Q. Okay. But in most cases, whatever it is?

A. Right.
Q. Internal reproductive organs, right?
A. Correct.
Q. External genitalia, right?
A. Yes.
Q. Brain structure, right?
A. Yes.
Q. That relates to those studies that we talked about before lunch, right?
A. Yes.
Q. And gender identity?
A. Yes.
Q. Okay.
A. Brain structure and brain development.
Q. Brain structure and brain development?
A. Yes.
Q. Those first four all fit into the category of anatomy, right?
MS. INGELHART: Objection, calls for speculation. You can answer.
BY THE WITNESS:
A. The first four I would say are physical and can be detected.
BY MR. BLAKE:

Q. All right. So in Paragraph 21 you say, "when there is divergence between anatomy and identity." Do you see that, that first clause?

A. Yes.

Q. So of the five components that you list there, only one is an identity component, right?

A. Yes.

Q. So the other four, correct me if I'm wrong, are anatomical, right?

MS. INGELHART: Objection, vague. You can answer.

BY THE WITNESS:

A. More or less.

BY MR. BLAKE:

Q. I mean, those are your words.

A. Yes.

Q. You said there's divergence between anatomy and identity. You know, chromosomal composition, that's not identity, right?

A. Correct.

Q. Internal reproductive, that's not identity, right?

A. Right.

Q. External genitalia, that's not identity,

right?

A. Right.

Q. Brain structure, brain development?

A. That's where identity lives.

Q. Is that a product of identity?

A. It's where identity arises.

Q. But you don't -- right, but you don't know if that has an anatomical or -- it's detectable biologically, right?

A. It's detectable only by imaging or autopsy.

Q. I guess you don't know whether it's a -- I guess it's kind of like a chicken and the egg, right? You don't know if the identity is shaping the anatomy or if the anatomy is shaping the identity, right?

MS. INGELHART: Objection, vague, misstates prior testimony, mischaracterizes prior testimony. You can answer.

BY MR. BLAKE:

Q. I mean, do you know?

A. What is the question?

Q. Well, the question is those brain studies that we talked about, right, which shape

the brain, influence brain development, right?

A. Right. Those are there at birth.

Q. At birth?

A. Yes, and they give rise to gender identity, and gender identity isn't visible, nor are those microstructures at birth, and only under sophisticated and rather new technology have we become aware of them, but the mind is where gender identity is, right? I mean --

Q. I don't know. You're the expert.

A. Well --

Q. I don't know.

A. How do you know that you're a man? Where does your sense of being a man lie? I mean, it's in your head. Even people who are developmentally disabled, autistic or brain damaged have a gender identity.

Q. So not every transgender person has the same indicia in their brain structure, right?

MS. INGELHART: Objection, vague, calls for speculation. You can answer.

BY MR. BLAKE:

Q. Do you know?

A. I don't think I understand the question.

Would you repeat it?

Q. Well, you know, you said that there's these brain studies that occurred and they identified some --

A. Four different brain phenotypes.

Q. Right. And that they found some correlation between transgender individuals and certain brain structure, right?

A. Not just brain structure but the brains of people who are transgender differ in the same way. They all differ in the same way from non-transgender brains.

Q. That's my question is that if you were to do a brain study of every single transgender person on the planet, would you find that they all had these difference in the same way?

MS. INGELHART: Objection, calls for speculation.

MR. BLAKE: These are the conclusions from the report. I mean, if the report reached that conclusion, great. If it didn't --

MS. INGELHART: Objection, mischaracterization of prior testimony. You can answer.

BY THE WITNESS:

A. People who are gender dysphoric, not all transgender people. Not all transgender people have had their brains imaged. Imaging studies have not been done on people who say they wish they would have been born in a different body, but they are not, they have some degree of gender incongruity.

The studies have been done on people who have a desire to transition and have been diagnosed as gender dysphoric, accepted into programs where they will receive medical interventions.

Those people, their brains differ in the same way. They differ in the microstructure. They differ in the cortical thickness. They differ in the putamen. They differ in many areas, but they differ in the same way.

So, for instance, my brain and this woman's brain are identical in some regard, but a trans man's brain would not look identical on imaging to her brain and my brain. There would be a difference. Does that --

BY MR. BLAKE:

Q. I'm just trying to figure out where to put this brain structure component. I think what you're describing are anatomical things that are discoverable from anatomy.

A. They are different in many ways.

Q. All right. But the structure of the brain is I think by definition anatomy, right?

MS. INGELHART: Objection. Actually maybe terms at issue. You can answer.

BY THE WITNESS:

A. I don't know if we would consider -- I guess the cortex in the area of the brain, I'm not an anatomist, but I would say that there are different -- you know that there are different areas of the brain.

BY MR. BLAKE:

Q. Of course.

A. And some of those areas are gray matter. Some of them are white matter. Some of them are, you know, the prefrontal cortex. Some of them is the corpus callosum that divides the brain. So, yes, the brain is a material organ.

Q. That can be observed, right?

MS. INGELHART: Can we just take a break here? I think we're --

BY THE WITNESS:

A. It could be observed with imaging.

MS. INGELHART: I think we're going in circles and I really need to go to the bathroom.

MR. BLAKE: I don't think we're going in circles.

BY THE WITNESS:

A. It can be observed by -- certain parts of it can be observed by imaging. Certain parts could be observed by cutting it open and looking at it.

(Whereupon, a short break in the proceedings was taken.)

MS. INGELHART: We are on the record. You wanted to clarify one quick thing from before about a couple cases or I can clarify on the record.

MR. BLAKE: Here we go.

MS. INGELHART: Neither Dr. Ettner or I can recall, but I'm on the papers on two cases that she previously was an expert on. I honestly don't know if we were ever on the same phone call but

it's possible.

MR. BLAKE: I was going to have some devastating impeachment.

THE WITNESS: I know I've never met you in person.

MS. INGELHART: I don't even know if on the phone. I wasn't lead on those cases.

THE WITNESS: I don't remember your name but --

MS. INGELHART: I didn't want you to look at the papers and see my name and get concerned.

MR. BLAKE: Dead to right. Saved yourself. You're lucky.

THE WITNESS: That's a big load off.

BY MR. BLAKE:

Q. So if the chromosome and the composition of an individual indicates male, are you with me? Yes?

A. If it's verified as male?

Q. Yes.

A. Like by karyotyping, yes.

Q. So chromosomal composition, varied by karyotyping, XY, male, right?

MS. INGELHART: Objection, hypothetical. You can answer.

BY THE WITNESS:

A. That doesn't mean the gender identity is male.

BY MR. BLAKE:

Q. I'm not talking about gender identity. We're going to get to gender identity. So chromosomal composition, XY karyotype?

A. Phenotype male.

Q. Phenotype male?

A. Correct.

Q. Internal reproductive organs consistent with male, are you with me?

A. Yes.

Q. Okay. External genitalia consistent with the chromosomal composition and the internal reproductive organs, so also normally male?

A. Yes.

Q. Okay. Brain structure, let's say it doesn't correspond with the indicia in that MRI study. Are you still with me?

A. Yes.

Q. So I guess a male brain would be what

that would indicate, right?

A. That it's --

Q. Normal male brain?

A. Okay. Typical male brain, not normal.

Q. Typical. I get it. Gender identity though identifies as female, okay? Are you with me?

A. No because then I would say that the phenotype of the brain is not typical male.

Q. Okay. Well, the MRI, the imaging of the brain doesn't reveal any of those four indicia that you have, right, pointed out in the study?

A. There's more than four. I've just listed four for the sake of our conversation.

Q. The MRI, the imaging study reveals typical male brain, but the gender identity of the individual, you know, the person identifies as female, all right? Still with me?

A. Is this a hypothetical that you're providing?

Q. It is.

MS. INGELHART: I just want to object that it's an incomplete hypothetical, but answer to the best of your ability.

THE WITNESS: Is there a question?
BY MR. BLAKE:
Q. Yes. What is that person's sex?
A. I don't know.
Q. Okay. So if they have -- if the anatomical components of a person's sex all indicate one sex but the identity component indicates another sex, you don't know what that person's sex is?
A. I would say if their identity is female, then their sex should be -- and they make a transition to present and live in the female gender, then female would be the answer to that question, to that hypothetical.
Q. And that's what you say in 21, right, "when there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation," right?
A. Yes.
Q. In that hypothetical and based on what you've said in Paragraph 21, gender identity outweighs the other four components, right?
A. Yes.

Q. So in that circumstance, there's really only one factor for determining a person's sex, right?

A. In the hypothetical that you have provided.

Q. And that's someone's gender identity, right?

A. Yes.

Q. In that circumstance, someone's anatomy is less relevant?

MS. INGELHART: Objection, vague. You can answer.

BY THE WITNESS:

A. Yes. I'm not sure I agree with all of the elements of your hypothetical, but I'm -- my opinion is that gender identity is paramount and takes precedent over anatomical or phenotypical features.

BY MR. BLAKE:

Q. Well, if that hypothetical person showed up to your office for a diagnosis, you certainly wouldn't try to convince them to live as their anatomical sex, right? That wouldn't be something you would try to do during your diagnosis, right?

MS. INGELHART: Objection, hypothetical, vague. You can answer.

BY THE WITNESS:

A. I would like to ask you to rephrase the question.

BY MR. BLAKE:

Q. Sure. The person who has a divergence between anatomy and identity, that person shows up in your office for a diagnosis, you're not going to say that their sex designation should conform to their anatomy, right?

A. I'm not going to say that.

Q. It's your opinion that the nonanatomical factor of gender identity is the determining factor in a person's sex, right?

A. Yes.

Q. And like you've written in the past, there's no test, medical or psychological, to diagnose transsexualism, right?

A. Correct. There is no blood test or physiological test. Some researchers have some valid instruments that they use, but they are not blood tests or urine tests or, you know, conclusive physiological measurements.

Q. What is the scientific basis for your statement that gender identity is a component of a person's sex?

MS. INGELHART: Objection, asked and answered. You can answer.

BY THE WITNESS:

A. I'm sorry, would you repeat it?

BY MR. BLAKE:

Q. Yeah. What is the scientific basis for your statement that gender identity is a component of a person's sex?

A. The scientific basis for that is that the American Medical Association and other medical organizations all concur that if a person's gender identity is incongruous with their anatomic sex and they wish to transition to living in their affirmed gender, then the American Medical Association and other organizations have medical protocols in accordance with the standards of care to implement that.

MR. BLAKE: This is 15.

(Document marked as Defendant's Exhibit No. 15.)

BY MR. BLAKE:

Q. The American Psychological Association, that's an organization to which you belong, correct?

A. Yes.

Q. I'm just going to read you, this is what I've just provided as Defendant's Exhibit 15, which is a printout from their web page, and specifically a frequently asked questions section.

At the bottom, the drop down menu says, "what is the difference between sex and gender?" Do you see that? Sorry, it's at the bottom of Page 1. Do you see?

A. I don't see that.

Q. There's a box at the bottom.

A. Oh, yes, I do see that. I'm sorry.

Q. And it says, "sex assigned at birth refers to one's biological status as either male or female and is associated primarily with physical attributes such as chromosomes, hormone prevalence and external and internal anatomy." Do you see that?

A. Yes.

Q. And it goes on and it says, "gender

refers to the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for boys and men or girls and women." Do you see that?

A. Yes.

Q. "These influence the ways that people act, interact and feel about themselves. While aspects of biological sex are similar across different cultures, aspects of gender may differ." Do you see that?

A. Yes.

Q. When the APA wrote that, they refer to sex as a biological status associated primarily with physical attributes. They didn't say physical attributes and gender identity, right?

A. Correct.

Q. Do you agree with that statement by the APA?

A. I agree with the statement that gender -- when they're referring to gender roles and gender presentation. I think that differs from gender identity. They're talking about gender expression.

Q. So you would agree that gender

expression does not play a role in a person's sex?

MS. INGELHART: Objection, misstates and mischaracterizes prior testimony.

BY THE WITNESS:

A. No, I wouldn't agree with the statement you've made.

BY MR. BLAKE:

Q. Do you agree that that the APA has not identified gender identity as being associated with sex in this statement?

MS. INGELHART: Objection, speculative and misstates prior testimony, mischaracterizes. You can answer.

BY THE WITNESS:

A. If I look further up, I see a sentence that says "gender identity refers to a person's internal sense of being male, female or something else. Gender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyle, voice or body characteristics." I agree with that statement.

BY MR. BLAKE:

Q. You agree with that statement?

A. Yes.

Q. And you agree that sex, what the APA says here is that "sex is assigned at birth and refers to one's biological status as either male or female." You agree with that?

A. Yes.

Q. You recognize the distinction between sex and gender, right?

MS. INGELHART: Objection, terms at issue. You can answer.

BY THE WITNESS:

A. I recognize a distinction between sex and gender identity.

(Document marked as Defendant's Exhibit No. 16.)

Q. The document you've just been handed has been marked as Defendant's 16.

A. Yes.

Q. This is an article titled "Adaptation and Adjustment in Children of Transsexual Parents."

A. Yes.

Q. And you are listed as one of the co-authors on this article. Do you see that?

A. Yes.

Q. Do you recognize this article?

A. I do.
Q. If you turn to the second page underneath the caption "methods and subjects," let me know when you're there.
A. I'm there.
Q. The first sentence says, "information was obtained from 27 parents with a history of TS who have undergone a transition to the opposite biological sex." Do you see that?
A. Yes.
Q. You wrote that, right, you or one of your co-authors?
A. Pardon me?
Q. You or one of your co-authors wrote that?
A. My co-author wrote this.
Q. Do you agree with that statement?
A. I agree with the statement that they have undergone a transition, yes.
Q. You didn't state that those parents underwent a transition to the opposite biological gender, right?
A. She did not write that. She wrote opposite biological sex.

Q. That wouldn't make sense. A person doesn't transition to the opposite biological gender, do they?

MS. INGELHART: Objection, terms at issue. You can answer.

BY THE WITNESS:

A. They transition to their affirmed gender, to another gender, to the opposite gender. We wouldn't now I don't think say to the opposite biological sex. I wouldn't have written that, and I wouldn't write that now. I certainly understand what the intention of what the meaning is and I definitely agree with that.

BY MR. BLAKE:

Q. You wouldn't write transition to the opposite biological gender because sex is biological, like the APA says, right?

A. I would write that they have undergone a gender transition.

Q. A person transitions to the opposite biological sex in order to bring his or her sex into alignment with their gender identity, right?

MS. INGELHART: Objection, terms at issue. You can answer.

BY THE WITNESS:

A. Is that something that you are reading from?

BY MR. BLAKE:

Q. No, it's a question. It's just a question.

A. What is the question?

Q. A person transitions to the opposite biological sex in order to bring his or her sex into alignment with their gender identity, right?

A. I wouldn't phrase it that way, but I think I understand what you're saying, and I agree with the concept, but I would phrase it differently.

Q. Is there a phrase or there's no such thing as biological gender identity, right?

MS. INGELHART: Objection, terms of the issue. You can answer.

BY THE WITNESS:

A. A person transitions from the sex which they were assigned at birth to their affirmed gender or to live in a gender other than the one that they were assigned at birth.

BY MR. BLAKE:

Q. Have you ever used in any writing or presentation the term biological gender identity?

A. It doesn't sound like something I have written or said, but as I sit here now, I can't recall everything that I've ever said or read or written.

Q. I'm not going to pull a document that says biological gender identity if that's what you're worried about.

A. No. No. It doesn't sound like anything that I or my colleagues have ever spoken.

Q. It doesn't make sense, does it?

A. Not really.

Q. Another interesting article, by the way.

A. Thank you.

MR. BLAKE: 17.

(Document marked as Defendant's Exhibit No. 17.)

THE WITNESS: Boy, I'm prolific, aren't I?

BY MR. BLAKE:

Q. You know, I must say you've

identified -- part of the reason why we went through the sort of song and dance in the beginning of the deposition for you to sort of point out for me was not to test your knowledge but to frankly educate myself.

Now I have, to the extent that there's not overlap, and there's some, I have more reading. I have more homework. I mean, I couldn't read, you know, a hundred articles. I just couldn't do it. Anyways, you've given me some homework.

All right. So I've just handed you what has been marked as Defendant's 17, and it is an article entitled "Disclosure of Risks and Protective Factors for Children Whose Parents Are Undergoing a Gender Transition." This is another article co-authored by you, right?

A. Yes.

Q. You recognize this article?

A. I do.

Q. All right. If you turn to the second page, the first paragraph is entitled introduction, and it looks like the third sentence in that paragraph which begins "the diagnostic and

statistical manual, 4th Edition, DSM-4 defines GID in adolescence and adults as a persistent desire to live as a member of the other sex." Do you see that?

A. No. What page are you on?

Q. I'm on the second page in the introduction.

A. Okay. Yes. Yes.

Q. All right. The third sentence begins, "the diagnostic and statistical manner," do you see that?

A. Yes.

Q. It goes on and says, "4th Edition, DSM-4 defines GID in adolescence and adults as a persistent desire to live as a member of the other sex." Do you see that?

A. Yes.

Q. Now, I understand that the DSM-4 has now been superseded by the DSM-5, right?

A. Yes.

Q. And the term GID is no longer used, they use gender dysphoria, right?

A. Yes.

Q. And they use certain criteria and

indicia of those two diagnoses which in your mind differ, you know, not in substantial ways, right?

A. Not just in my mind.

Q. In everyone's mind.

A. Correct.

Q. Or at least the folks at the APA.

A. Which is the reason why it was changed, yes.

Q. Which is the reason why it was changed in the DSM?

A. Correct.

Q. Fair enough.

The question I have for you though is at the time you and your co-author wrote that -- well, what you didn't write, sorry, that transgender people have a persistent desire to live as a member of the other gender, right?

A. Correct.

Q. That's because gender and sex in this context are different, right?

MS. INGELHART: Objection, terms at issue. You can answer.

BY THE WITNESS:

A. Again Tanya White wrote this article.

We did the data collection together, and the writing is hers, and we -- I don't know if back then it would have occurred to her to phrase it in the way you're saying, but what you have stated is the way that it is written here, the other sex.

BY MR. BLAKE:

Q. Do you disavow this article?

A. No, I do not.

Q. In fact, you agree that sex and gender are actually totally different concepts, right?

MS. INGELHART: Objection, misstates prior testimony.

BY THE WITNESS:

A. No, I do not.

BY MR. BLAKE:

Q. I'm reading from Confessions of a Gender Defender again, Page 128. At the very top of the page, and I'm happy to show it to you, "there is a tendency in western societies to confuse sex with gender. They are truly different concepts." Do you recall writing that?

A. That's referring to sexual orientation or sexual activity, not sex as our conversation today, chromosomes and the categories of male and

female.

Q. Okay. So just placed in its proper context, you agree with that statement?

A. The statement as it is written here?

Q. The statement as it's written in your book.

A. Yes, which is why I said that transsexualism was no longer a term that was in common parlance because it conflated sex which for lay people means sexual orientation, sexual behavior with gender.

Q. Go back to Defendant's Exhibit 11 which is your expert report. We're going to move on from Page 5, you'll be happy to know. It's an illuminating page clearly. We're going to skip Page 6 and Page 7, and we're going to settle on Page 8.

A. 8?

Q. Yes, Paragraph 31. And I believe this is the paragraph that we talked about briefly at the beginning of the deposition about the 2015 study related to suicide rates or risk among transgender community, right?

A. Yes.

Q. And instead of spending a lot of time on inquiry over who authored the study and things of that nature, I think I understand that now, but I do have some general questions about how the study was conducted and its findings, so I would just like to spend a few minutes on that.

You write on Page 9, and this is just, you know, a part of the sentence, but it says "demonstrating that in a hypothetical sampling of a thousand transgender people." What do you mean by hypothetical sampling?

A. If you were to take 1,000 people, which of course we can't do, but hypothetically if we could gather 1,000 subjects.

Q. In this case transgender people, right?

A. Correct. According to their Bauer, et al, the study that they did, what they found in their results was that completing a medical transition related to a decrease in suicide ideation and attempts, and having congruent identity documents likewise conferred a protective -- had a protective effect on transgender people.

Q. You conclude or they conclude and you

report that of the -- out of the thousand hypothetical transgender people who have permitted a change in identity documents, 90 cases of ideation could be prevented, right.

A. Yes, that's their conclusion.

Q. That's their conclusion.

Help me out. What's the difference between ideation and actual suicide?

A. Well, actually there's three components here. Ideation is the person who thinks about suicide and contemplates committing suicide and plans how they would execute a suicide.

A suicide attempt is someone who actually hurts themselves with the attempt of ending their life, and a completed suicide is someone who is successful.

Q. Okay. I think I understand which explains the second part where you say, this is another hypothetical group, which is even more difficult to locate, and these are the 1,000 hypothetical transgender people who have the ideation, right, the ideation of suicide?

A. Yes.

Q. So you would need 90,000 hypothetical

transgender people to get a group that large. I think that's right.

A. I would have to review their methods. I only can say that this article is peer reviewed, so apparently statistically and methodologically it was rigorous enough.

Q. To pass that threshold?

A. Oh, yes, and to be in a journal with an impact factor. So I would have to reread it to see how they actually -- you know, look at their statistical methodology.

Q. So out of -- I'm just trying to make sure I understand. You got a hypothetical group of a thousand transgender people, right?

A. We know that transgender people, the majority or like almost 50 percent have attempted suicide. 43 percent is what the Williams Institute has documented have made attempts. So here with this massive study that they have done, they've shown that 230 of those --

Q. Attempts?

A. -- attempts could have been prevented. So there's something protective is ultimately the distillate of this research.

Q. So a quarter, roughly a quarter of the people who -- quarter of the transgender people who attempt suicide could be prevented with proper documentation?

A. According to this study.

Q. According to the study?

A. And their findings. What we know is that regardless of the numbers, we know and the standard of care tells us that having congruent identity documents attenuate gender dysphoria.

The attempted suicides are a result, many of them or a quarter of them are likely the result of gender dysphoria. Perhaps some of them are related to some other mental illness.

Q. That's called like co-morbidity, right?

A. Co-occurring morbidity or co-morbidity.

Q. Where you have lots of different psychological problems running sort of in parallel?

A. Correct.

Q. May or may not be related?

A. Correct.

Q. It's kind of hard to tell and frankly probably immaterial, right? You want to treat the person as opposed to --

A. Treat all.
Q. Right. Do you know what their actual non-hypothetical sample size was?
A. No, I would have to review the article.
Q. It's in the report. I can get it in the report if I was interested, right?
A. Okay.
Q. I mean, I just was asking if you knew offhand.
A. Yes.
Q. I didn't have a chance to look at it before.
Now, at this point -- Now, this study was conducted in 2015?
A. 2015.
Q. So four years ago give or take. It's a study out of Canada, right?
A. Correct.
Q. Do you know offhand whether the sample -- the people they sampled were Canadian or from the United States? Do you know?
A. I believe they were from Ontario, but I would have to review the article.
Q. Do you know what Ontario's laws are

regarding changing your identity, changing the sex marker, gender marker?

A. No, not offhand.

Q. You don't know if Canada just lets people?

A. Some provinces I believe do because there is a CPAP chapter, so at one point we reviewed that, but I don't recall.

Q. Well, do you know what kind of identity documents were involved in the study?

A. I don't recall.

Q. Do you recall if that was indicated in the study?

A. I don't recall.

Q. So it could have been like whatever their equivalent of a driver's license is in Canada? It's probably called a driver's license.

MS. INGELHART: Objection, speculation. You can answer.

BY MR. BLAKE:

Q. It could have been that, right?

A. I would have to review the article.

Q. Okay. Don't know if it was a birth certificate though, right?

A. I don't know what documents they are referring to.

Q. Do you know whether the study even controlled for the type of identity document involved?

A. I don't know the methodology of the study without rereading it.

Q. Do you know whether the study controlled for individuals who were born in a province that allowed for these types of changes to the identity documents to occur?

A. I don't recall.

Q. Do you know just as a general matter whether transgender individuals born in a province or even state like the United States have a higher or lower rate of suicide if they are born in a state or province that doesn't allow them to make these changes to their identity documents?

A. I don't know of any documentation to that effect. I know there's an article that documents more suicide in states that have sex segregated facilities.

Q. You mean like bathrooms and locker rooms?

A. Uh-huh, and dormitories.
Q. So do you have the name of that? Is it in your bibliography?
A. It might be in my bibliography.
Q. Go ahead and see if you can find it.
A. "Trans Adults Access to College Bathrooms."
Q. What page are you on?
A. I'm on Page 4.
Q. Page 4 of Exhibit B to the --
A. That's the Seelman article, 2016.
Q. Page 4 to Exhibit B to Defendant's Exhibit 11, the Seelman article, "Trans Adults Access to College Bathrooms and Housing in relationship to Suicidality." Is that the article?
A. Yes.
Q. And your understanding of that article is that in those states where segregated -- with segregated access, rates of suicides are higher?
A. Yes.
Q. Okay. Do you know whether the 2015 Ontario study controlled for people who had a diagnosis of gender dysphoria?

A. I don't know that.
Q. Do you know if the study controlled for people in varying stages of transition?
A. I don't recall.
Q. Do you believe a diagnosis of gender dysphoria should be required before a person is able to change the sex marker on his or her birth certificates?
MS. INGELHART: Objection, calls for a legal conclusion. You can answer.
BY THE WITNESS:
A. Would you repeat the question?
BY MR. BLAKE:
Q. Yeah. Do you believe that a diagnosis of gender dysphoria should be required before a person is able to change the sex marker on his or her birth certificate?
MS. INGELHART: Also objection to incomplete hypothetical. You can answer.
BY THE WITNESS:
A. I don't believe that, no.
BY MR. BLAKE:
Q. Do you believe that a person needs to undergo a certain amount of transition before

requesting a change to the sex marker on their birth certificate?

MS. INGELHART: Same objection as to legal conclusion and incomplete hypothetical. You can answer.

BY THE WITNESS:

A. I'm not certain what you mean by a certain amount of transition.

BY MR. BLAKE:

Q. Well, I mean, there are like stages of transition, right? A person will come to you, for example, and say, you know, I'm -- I feel my gender is incongruous with my sex. They probably won't say it like that. They probably never do. But, right, I mean, that's the sort of --

A. There's a self disclosure.

Q. Some sort of self disclosure. And then you would diagnose them oftentimes with gender dysphoria but not all the times, right?

A. If I make a diagnosis.

Q. If you make a diagnosis. The next step for that person if they choose is to start undergoing a transition of some sort, right?

A. Not necessarily.

Q. Well, if they choose. They don't have to. They can continue presenting themselves and living as their sex assigned at birth if they choose?

A. Correct.

Q. But in the case of someone who doesn't want to do that, the next logical step for them is to start making steps towards transition, right?

A. Some people might undergo a social transition.

Q. Right. And so that would be sort of the least friction, like easiest -- well, maybe not easy, but, you know, first step that some people choose to undertake?

A. Not necessarily. Some people might undergo hormonal --

Q. That's another example of a step towards transition that someone can take, right?

A. Someone could undergo a hormonal intervention.

Q. Right.

A. Without transitioning socially.

Q. Correct. Someone could also change their name, that would be another step someone

could take to be more male or female, right?

A. If they choose.

Q. If they choose, right. That's another step in transition, right? And sort of, I suppose, the most drastic step is for people to undergo a medical procedure to actually have parts of their anatomy changed to conform with their gender identity, right?

MS. INGELHART: Objection, vague. You can answer.

BY MR. BLAKE:

Q. That's another step in the transition, right?

A. I'm assuming you're talking about a surgical intervention, not a medical intervention.

Q. Surgical, yes. So those are all steps I think in a person's transition that they can choose to take and they don't have to take them in order?

A. They are all options for people.

Q. And you can do them in any order you want?

A. No. You can't have certain interventions without first having preliminary

interventions.

Q. Yeah, I understand that. That's the law. I don't know if it's in most states or all states but you have to --

A. It's the standard of care.

Q. You have to live or transition certain parts of your life before you do some of the like more permanent surgical interventions, right?

A. There are certain criteria that have to be met before people can have medical or surgical interventions.

Q. Understood.

So setting those aside, there are some preliminary steps in transition that a person can undergo, right?

A. Prior to medical interventions or surgical interventions.

Q. Okay. So that's what I talk about when I say certain transition. That's what I mean, the steps in a transition.

So do you believe a person needs to undergo a certain number of those steps in transition before they are able to request a change on the sex marker of their birth certificate?

MS. INGELHART: Objection, calls for a legal conclusion. You can answer.

BY THE WITNESS:

A. My answer is that it's not what I believe. My experience is that when people socially transition and present in a gender other than the one in which they were assigned, then they will request to have congruent identity so that their daily interactions are safe and private and allow them to live safely and comfortably in their affirmed gender.

BY MR. BLAKE:

Q. Your experience is people socially transition prior to requesting these changes to their identification documents?

A. The majority of people would do so.

Q. But you don't believe that that's a requirement, right?

MS. INGELHART: Objection, calls for a legal conclusion. You can answer.

BY THE WITNESS:

A. I don't know that there's a requirement. I think that different states have different requirements, and I'm not privy to all of that. My

experience is with the people who actually do undergo transitions and then try to have documents that reflect their lived experience.

BY MR. BLAKE:

Q. And it's not your opinion or belief that someone should have to undergo hormone therapy before requesting a change to their identity documents, right?

MS. INGELHART: Same objection, legal conclusion. You can answer.

BY THE WITNESS:

A. I don't believe people should have to undergo hormonal therapy prior to having congruent documents.

BY MR. BLAKE:

Q. You don't believe someone should have to undergo some amount of surgical intervention before having congruent identity documents, right?

A. Correct.

MS. INGELHART: Same objection to legal conclusion and incomplete hypothetical.

THE WITNESS: I'm sorry I spoke before you entered your objection.

MS. INGELHART: It's okay.

BY MR. BLAKE:

Q. Would you agree that no amount of gender transition can change a person's chromosomes, right?

MS. INGELHART: Objection, calls for speculation and incomplete hypothetical. You can answer.

BY THE WITNESS:

A. I don't think that chromosomes change with a gender transition.

BY MR. BLAKE:

Q. And no amount of gender transition can change the sex of the individual as identified by the medical provider at the time of birth, right?

MS. INGELHART: Objection, calls for -- well, objection to terms and legal conclusion and speculation. You can answer. Incomplete hypothetical.

BY THE WITNESS:

A. I don't understand the question.

BY MR. BLAKE:

Q. Sure. There's a sex identified at the time of birth?

A. Correct.

Q. Based on what you described as a cursory inspection of the external genitalia, right?
A. Yes.
Q. No amount of gender transition can change that?
A. No, I believe birth certificates are changed routinely in 48 states.
Q. Right, but that doesn't change the sex that was observed and reported by the medical provider at the time of birth?
A. Correct, it doesn't change --
MS. INGELHART: Objection.
BY THE WITNESS:
A. -- the primary sex characteristic of the infant.
BY MR. BLAKE:
Q. You said you reviewed the complaint prior to drafting your expert opinion, right?
A. Yes.
Q. Do you know whether any of the plaintiffs feared physical harm when they disclosed their birth certificate based on what you reviewed in the complaint?
A. Yes.

Q. And do you believe that they feared physical harm when they disclosed their birth certificates?

A. I believe that knowing that their birth certificates were inconsistent with their gender presentation, they were always fearful of having to expose that.

Q. But did they fear physical harm?

A. Oh, I don't know if they feared physical harm. I'm going to have to ask to take a break and go to the restroom.

Q. Okay.

(Whereupon, a short break in the proceedings was taken.)

MR. BLAKE: Back on the record.

BY MR. BLAKE:

Q. With regards to any of the plaintiffs in this case, do you believe that the medical provider made an error when the sex was recorded on his or her birth certificates?

A. No.

Q. Do you believe that medical providers in general should be required to conduct any additional medical procedures to determine a

child's sex at birth?

A. No.

(Document marked as Defendant's Exhibit No. 18.)

Q. I just handed you what has been marked as Defendant's Exhibit 18 which is a copy of the expert report submitted by Dr. Van Meter. Have you seen this document before?

A. Yes.

Q. Okay. In fact, you said you reviewed these documents after you submitted your report, right?

A. Yes.

Q. I'm going to ask you to turn to Page 3 in Paragraph 14. "From the moment of conception, a fetus is determined to be either a male XY, female XX or in rare cases to have a combination of sex determining chromosomes, many of which are not compatible with life and some of which are the cause of identifiable clinical syndromes." Do you see that sentence?

A. I do.

Q. Do you agree with that?

A. Yes.

Q. "The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop a testicle." Do you agree with that conclusion?

A. Yes.

Q. "The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary." Do you agree with that?

A. Yes.

Q. "Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to develop a penis and a scrotum." Do you agree with that conclusion?

A. More or less.

Q. "Simultaneously the testicle produces anti-mullerian hormone, AMH, which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes and upper third of the vagina." Do you agree with that conclusion?

A. Yes.

Q. "There is no process or procedure that will alter a person's chromosomes." You agree with

that, right?

A. Yes.

Q. Paragraph 15. Let me see if I can short circuit of this. If you would please read Paragraph 15 and let me know if you agree with the conclusions in Paragraph 15. You can read it silently if you prefer.

A. I agree with Paragraph 15.

Q. All right. Same question for Paragraph 16, is there any conclusion in Paragraph 16 with which you disagree?

A. I believe I disagree with No. 16.

Q. Which part of Paragraph 16 do you disagree with?

A. The incidents of disorders of sexual differentiation.

Q. Okay. "The incidents of such circumstances occurs in 1 out of 4,500 to 1 in 5,500 births," is that the part you disagree with?

A. Yes. I'm not certain that I agree with those numbers, and I would have to look at my own sources, which I don't have with me.

Q. You think the rate of DSD might be higher?

A. I do.
Q. Okay. And by DSD we mean disorders of sexual differentiation?
A. Correct.
Q. But other than that, you agree with the rest of the conclusions in Paragraph 16?
A. Yes.
Q. Paragraph 17, do you disagree with any conclusions in Paragraph 17?
A. I disagree with 17.
Q. What aspect of Paragraph 17 do you disagree with?
A. I don't think sex is necessarily binary. I think that chromosomes are one component of sex, and I don't think that it's the Intersex Society of North America that puts out that consensus statement, but I am not certain about that.
Q. Sex assigned at birth is, in the absence of a disorder, male or female, right?
A. Yes. It is designated clerically, yes.
Q. You agree that that designation itself would be binary in the normal circumstance, right?
A. Yes.
Q. You said you also agreed with the 2016

consensus statement of the Intersex Society of North America?

A. No, I don't believe that is the Intersex Society of North America that made that statement, but I'm not certain about that. In other words, I'm not certain that I agree and will not state that I agree with Paragraph No. 17 in its entirety.

Q. Right. But you said disagreed with sex is binary male or female, that aspect of it, right?

A. I disagree with that.

Q. Okay. But you agree that the sex as identified at birth is in the normal circumstances binary, correct?

A. It's documented as being binary.

Q. You disagree with sex being determined by chromosomal complement?

A. Alone.

Q. And your basis for disagreement are those five components that we talked with earlier?

A. Correct.

Q. Okay. Then you disagree with the way that Dr. Van Meter has identified this 2006

consensus statement?

A. I would need to myself see documentation before I would agree with that statement. I don't know.

Q. You just don't know what the statement is that he's referring to?

A. I don't know what the statement is, but I think the Intersex Society of North America, if it's what I think it is, then I am not in agreement with that, that they are the source of that statement.

Q. Okay. It's not that you -- you don't take issue with -- I guess I was confused. Do you think that the Intersex Society of North America exists?

A. I'm not certain that that statement is accurate, that's my opinion, as it's written.

Q. In what way is it inaccurate?

A. I'm not certain that it's accurate the way it's written.

Q. Okay. Is there an organization called the Intersex Society of North America?

A. There is an Intersex Society, and it is made up of consumers, and I'm not certain that this

is their consensus statement. I don't know. I would have to check that.

Q. Okay. Go to Paragraph 19. Read that and let me know if you agree with the conclusions in that paragraph.

A. I do not.

Q. Which conclusions do you disagree with?

A. In the first sentence DSD patients are not transgender. Some, in fact, are.

Q. Some, but not all, right?

A. This conclusively says DSD patients are not transgender.

Q. Okay. Is there anything --

A. I do not agree with that statement.

Q. Is there anything about a DSD patient that makes them more or less likely to be transgender --

A. Yes.

Q. -- in your opinion?

A. Yes, they are more likely to be transgender than the normal population because they have some anomalies.

Q. One of those components of sex is somewhat ambiguous?

A. Correct.

Q. Do you disagree with anything else in Paragraph 19?

A. I don't know. I'm not an expert on DSD, so I don't want to overstate my agreement or disagreement with diagnostic subgroups of the chromosomal anomalies.

Q. Okay. So that the conclusions in 19 are outside your area of expertise and you are not offering an opinion one way or the other on those conclusions?

A. I'm offering an opinion that the statement DSD patients are not transgender. Some DSD patients are transgender and do make gender transitions.

Q. Okay.

A. I disagree with the statement that says people who identify as feeling like the opposite sex or somewhere in between do not comprise a third sex. Transgender people don't feel like the opposite section. They have a gender identity that is incongruous and it's not based upon a feeling. They meet certain criteria as outlined in the DSM-5 as we have already discussed.

Q. Paragraph 21, do you agree with the conclusions in that paragraph?

A. I don't know that gender is a psychological concept, I've never heard that before, or a sociological term. I don't agree that it possesses a linguistic, solely a linguistic meaning prior to the 1950s. I've never seen any documentation of that.

I don't know what sexologists manipulated the term to conceptual cross dressing and transsexualism in their psychological practice. I disagree with that. That doesn't comport with my understanding of this field that I specialize in.

Q. What are the origins of the gender and gender diversity and transgender specialization of your practice?

MS. INGELHART: Objection, vague. You can answer.

BY THE WITNESS:

A. I'm sorry, can you be more specific?

BY MR. BLAKE:

Q. So, I mean, you identified four areas which you have expertise in and within the field of

psychology, right?

A. Correct.

Q. And one of those relates to the transgender issues we've been talking about today, right?

A. Yes.

Q. Historically, right, what are sort of the origins of that branch your practice?

A. Well, as I mentioned before, I started seeing individuals who were patients in the late '70s. My aunt was Harry Benjamin's disciple. Harry Benjamin was the person who first introduced the term transsexualism, as you may know, and wrote the book The Transsexual Phenomenon. Christine Jorgensen was his seventh patient.

Q. That was in the 1950s?

A. 1950s, correct. She was his patient in I think -- well, she was his seventh patient. She came back from Denmark and came to the United States. In Denmark she had a partial sex change and she needed to complete her surgery in the United States.

In BC, Ovid, the BC poet, talked about the pregnant -- the yearn of a pregnant mare

to change one's sex which is Premarin, which is still in use today. It's a female estrogen. So there have been transgender people since the beginning of history and they exist in all cultures.

So this idea that sexologists manipulated gender to conceptualize cross dressing and transsexualism in their psychological practice, I don't know what sexologists your expert is referring to. I don't know whose psychological practice or what psychological practice this refers to. So Paragraph 21 I think is rather meaningless to me.

Q. You may disagree with the way he characterized things in Paragraph 21, but you would agree that at least that modern transgender studies has its origins with Harry Benjamin in the 1950s; is there accurate?

A. Harry Benjamin coined the phrase transsexual, but Magnus Hirschfield in Germany in the '30s, I believe, described individuals who had a need to present in a gender that was other than that which they were assigned at birth in what you call detransvestism, so the phenomenon has existed

for years, but it was only really with Christine Jorgensen that it became known to the public in the '50s.

Q. In the '50s?

A. Yes.

Q. Okay. Paragraph 22, do you agree with the conclusions in that paragraph?

A. I don't know when John Money termed the --

Q. Termed the gender identity phrase? Setting aside the chronology, you know, as far as the content of Paragraph 22.

A. I would agree that most individuals have a gender identity that aligns with their assigned sex. I would not say that gender incongruity is a psychological condition.

Q. Move down to Paragraph 23.

A. Yes.

Q. You disagree with gender incongruity as a psychological condition?

A. Yes, I wouldn't describe it primarily as a psychological condition.

Q. Would you agree with the conclusion in Paragraph 24?

A. I don't agree with that.
Q. You disagree with the --
A. With the way that's phrased, yes.
Q. With gender incongruity?
A. I'm disagreeing with this idea that he or she will often express the belief that he or she is the opposite sex.
Q. I got it. You rejected Paragraph 23. I am on to Paragraph 24. Do you disagree with the conclusions?
A. Paragraph 24 is wrong.
Q. In what way?
A. In the way that in 2016 or the 2016 epidemiologists at Emery University concluded that a gender incongruity occurs in between .2 and .7 percent of the population.
Q. So you think the numbers are higher?
A. Oh, the numbers are definitely higher.
Q. Paragraph 25, do you agree with the conclusions in that paragraph?
A. Gender dysphoria is a medical condition, and it does cause emotional distress.
Q. So more or less other than maybe the use of the term gender incongruity?

A. No, gender incongruity is probably --
Q. Accurate?
A. Well, the World Health Organization in the next international classification in ICD will probably use the term gender incongruity. We actually met with members of the World Health Organization and decided that that was an appropriate term.
Q. So 25, there's nothing offensive about 25?
A. Well, I wouldn't call gender dysphoria a diagnostic term.
Q. What kind of term would you call it?
A. I would call it a medical condition.
Q. Okay. Medical condition.
A. Yes.
Q. Otherwise you're perfectly fine with that statement?
MS. INGELHART: Objection, mischaracterizes prior statement.
BY THE WITNESS:
A. I wouldn't say I'm perfectly fine. I would say that it's a medical condition that is diagnosed when a person experiences significant

clinical distress that impairs their ability to function in a particular area, which is the DSM-5 definition.

BY MR. BLAKE:

Q. You would adopt the DSM-5 definition for gender dysphoria?

A. Yes.

Q. Paragraph 26, do you agree with the conclusions in that paragraph?

A. I agree with the first sentence that there's no observable physical way to test for gender dysphoria in the womb or at the time of birth. I agree with that statement.

Q. Do you agree with the second sentence too?

A. Yes.

Q. And I assume you agree with the last sentence as well?

A. Gender nonconforming has been reported in patients younger than four years of age.

Q. Even younger than four?

A. Uh-huh.

Q. And Paragraph 27, do you agree with the conclusions in paragraph?

A. Chromosomes cannot be changed by a medical procedure, I agree with that.

Q. Paragraph 29, do you agree with that statement?

A. I agree that the birth certificates record an individual's primary sex characteristics at the moment of birth.

Q. And Paragraph 30, you agree with, right?

A. Yes.

Q. None of the plaintiffs have had karyotyping done, so I assume if I asked you whether or not you would agree with Dr. Van Meter's opinion regarding what their chromosomes are, you would say you don't have any information one way or the other on that; is that accurate?

A. I would say not only do I not have that information, I would say that he doesn't have that information either.

Q. Would you agree though that most likely their karyotype conforms with their sex assigned at birth?

MS. INGELHART: Objection.

BY THE WITNESS:

A. I can't make that statement. I would say in most cases, people's chromosomes do, and that's true even of people who have gender dysphoria; however, there is a higher incidents of chromosomal anomalies in people who are gender dysphoric, so for any given gender dysphoric person, I can't state what their chromosomes are or are not.

Q. It might be less likely than you or me or more likely than you or me that they have some sort of chromosomal abnormality, but still more likely than not that they have the normal karyotype; is that accurate?

A. That seems like a fair statement to make.

MR. BLAKE: I have no further questions.

MS. INGELHART: Thank you. We'd like to take a quick break.

MR. BLAKE: You just had a 30 minute break. How long is it going to be? Off the record.

(Whereupon, a short break in the proceedings was taken.)

MS. INGELHART: Back on the record.

Thank you. Plaintiff's counsel has just a few questions for direct. I will instruct the witness to remember that the court reporter is still to your left so if you can project out so she can best record.

E X A M I N A T I O N

BY MS. INGELHART:

Q. First I'm going to refer back to Defendant's Exhibit 18 which is Dr. Van Meter's initial expert report. Can we look to Page 5, Paragraph 27?

Previously you testified that you agreed with the first three sentences in this paragraph.

A. I'm sorry, what paragraph?

Q. I will refer back now that opposing counsel has reached the same page. Apologies.

We're looking at Paragraph 27. Previously you testified that you concurred with the first three sentences of this paragraph. That's accurate, correct?

MR. BLAKE: Objection, misstates.

MS. INGELHART: I'll retract it.

BY MS. INGELHART:

Q. Do you agree that there are no procedures, medical or otherwise, by which an individual can change chromosomes that determine sex?

A. I agree. Chromosomes cannot be changed.

Q. Do you agree that hormone therapy, surgical modifications can't change chromosomes one is born with?

A. I agree with that statement.

Q. Do you agree that sex is innate?

A. I don't agree with that. I don't know what that refers to, that sex. I don't know what -- how he's conceptualizing sex.

Q. Thank you.

Do you agree that there's no credible science proving that gender incongruity is innate?

A. I do not agree with that.

Q. Do you agree with this last sentence here then in Paragraph 27?

A. I do not.

Q. Thank you.

Referring down on the same page to Paragraph 30, I would like to revisit prior

testimony. Do you agree that gender identity is not observable or detectable at the time of birth?

A. I agree with that.

Q. Do you agree that gender identity is not recorded on Ohio birth certificates?

A. Yes.

Q. What is recorded on Ohio birth certificates?

A. The infant's primary sex characteristic. Penis or vagina is what is recorded as male or female at the time of birth.

Q. Thank you.

In your experience, would it support a binary transgender person's social transition to have a binary gender or sex marker that matches their gender identity on their birth certificate?

MR. BLAKE: Objection, vague.

BY THE WITNESS:

A. Yes.

BY MS. INGELHART:

Q. In your experience, what kind of requirements for accessing accurate identity documents, ones that match a transgender person's

gender identity, have been correlated with the most affirming social transitions?

A. Those that are least burdensome.

Q. Thank you.

Some terms of art were used today interchangeably with antiquated terms. Generally why has medical society evolved from using terms like natal sex to sex assigned at birth or transsexual to gender dysphoria?

A. Natal implies something that is permanent. Sex assigned at birth is temporal. Transsexualism conflates sex, be it sexual orientation, sexual behaviors or sexual activity with gender, and lay people in particular confuse sexuality with gender leading to some serious negative connotations for people who are transgender.

Q. Is the term sex assigned at birth more accurate than natal sex?

A. Yes.

MR. BLAKE: Objection.

BY MS. INGELHART:

Q. Is the term gender dysphoria a more accurate term than transsexual?

MR. BLAKE: Objection.
BY THE WITNESS:
A. Yes.
BY MS. INGELHART:
Q. Have you ever had a client or patient face negative outcomes as a result of experiences or instances related to inaccurate identity documents, identity documents that did not correlate or match their gender identity?
A. Yes.
Q. Can you please provide an example?
A. I had a patient who committed suicide, shot herself in the head after producing a document that didn't align with her gender presentation. She went home and killed herself. That was one unfortunate and very dramatic occasion.

On another occasion a woman who was a trans woman who had transitioned as an adolescent and was married, although she was an extremely authentic and actually a very beautiful woman, someone revealed a document that had a male birth name on it, and she and her husband were so victimized and harassed by co-workers, they had their brake lines cut, death threats.

The workers took out a petition that she couldn't use the female restroom. They smeared feces on her desk. She and her husband developed -- her husband was taunted for being gay because he was married to someone who was really a man and people would bring sex toys to his office.

They are both completely disabled. They are unable to leave their homes. They have panic attacks. The man pulled all his hair out of his head and lost 50 pounds in a month, and they are both on permanent, extended disability and are physically and psychologically damaged, extremely damaged.

Q. Just to clarify, that classification as disabled is a result of the harassment; is that correct?

A. Yes. They have what is known as complex PTSD. Complex PTSD is unlike random PTSD which is acts of God, like a tornado or a car accident. Complex PTSD is caused by human beings. It's intentional and it occurs intermittently and repeatedly so people don't have time to regain their equilibrium in between these assaults, and so it's more intractable and more severe than random

acts of God which aren't personal.

MS. INGELHART: Thank you. I don't have any further questions.

MR. BLAKE: I don't have any followup questions.

MS. INGELHART: We would like to have the opportunity to sign later.

(Witness excused.)

REPORTER CERTIFICATE

I, MARI BETH KAWULIA, a Certified Shorthand Reporter within and for the County of Cook and State of Illinois, do hereby certify:

That previous to the commencement of the examination of the witness, the witness was duly sworn to testify the whole truth concerning the matters herein;

That the foregoing deposition transcript was reported stenographically by me, was thereafter reduced to typewriting under my personal direction and constitutes a true record of the testimony given and the proceedings had;

That the said deposition was taken before me at the time and place specified;

That I am not a relative or employee or attorney or counsel, nor a relative or employee of such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand this October 7, 2019.

Mari Beth Kawulia

MARI BETH KAWULIA, CSR

C.S.R. No. 84-2873

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

October 7, 2019

To: KARA N. INGELHART

Case Name: Ray, Stacie, et al. v. Acton, Amy, etc., et al.

Veritext Reference Number: 3493804

Witness: Randi Ettner, Ph.D. Deposition Date: 9/18/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493804
CASE NAME: Ray, Stacie, et al. v. Acton, Amy, etc., et al.
DATE OF DEPOSITION: 9/18/2019
WITNESS' NAME: Randi Ettner, Ph.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Randi Ettner, Ph.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493804
CASE NAME: Ray, Stacie, et al. v. Acton, Amy, etc., et al.
DATE OF DEPOSITION: 9/18/2019
WITNESS' NAME: Randi Ettner, Ph.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

10.25.19 Randi Ettner, PhD.
Date Randi Ettner, Ph.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 25 day of October 2019.

Sara Aldape
Notary Public

Official Seal
SARA ALDAPE
Notary Public State of Illinois
My Commission Expires 07/26/2021

7/26/2021
Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3493804

PAGE/LINE(S) /	CHANGE	/REASON
42:15	/Sania change to Soneeya	/spelling
194:7	/CPAP Change to CPATH	/wrong word
216:24	/yearn change to urine	/wrong word

_____ _____

Date Randi Ettner, Ph.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____ .

_____

Notary Public

_____

Commission Expiration Date

d

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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