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IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

STACIE RAY, BASIL)
ARGENTO, JANE DOE and)
ASHLEY BREDA,)
)
Plaintiffs,)

No. 2:18-cv-00272-
MHW-CMV

vs

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

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I N D E X

WITNESS:

RANDI ETTNER, Ph.D.

Direct Examination by Mr. Blake.....4

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EXHIBIT	DESCRIPTION	PAGE
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1 (Witness duly sworn.)

2 WHEREUPON:

3 RANDI ETTNER, Ph.D.,
4 called as a witness herein, having been first duly
5 sworn, was examined and testified as follows:

6 DIRECT EXAMINATION
7 BY MR. BLAKE:

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

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

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

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

19 A. I am.

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

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

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

5 Q. Great. Thank you.

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

11 A. That's correct.

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

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

1 going to assume that you understood the question.

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

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

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

11 A. Correct.

12 Q. Tests and measurements, what's that?

13 A. Psychologists are trained to give
14 psychodiagnostic tests.

15 Q. So could you give me an example?

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

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

24 A. No. There is no test for gender

1 dysphoria per se.

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

6 A. That's my understanding.

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

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

19 Q. Like a DSM?

20 A. Correct.

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

24 A. One could use a test to determine a

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

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

7 A. Yes.

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

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

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

19 Q. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 anorexic. Are you with me so far?

2 A. Yes.

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

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

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

10 A. That's correct.

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

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

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

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

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

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

10 A. I think I agree with that statement.

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

15 A. Only if you all have the appropriate
16 insurance.

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

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

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

24 So general psychology, PTSD, tests

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

3 A. Correct.

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

7 A. Yes.

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

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

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

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

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

19 A. That's correct.

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

21 A. Yes.

22 Q. You received a masters as well?

23 A. Yes.

24 Q. Kind of the normal four-year degree

1 masters, Ph.D. track program, right?

2 A. Yes.

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

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

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

11 A. In 1980 I began practicing privately.

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

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

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

1 experience with people who were experiencing gender
2 incongruity.

3 Q. Okay. And that would have been
4 approximately?

5 A. In the late '70s.

6 Q. Was that during your doctoral?

7 A. No.

8 Q. Before that?

9 A. Yes.

10 Q. Masters?

11 A. Before.

12 Q. So as an undergrad?

13 A. Yes.

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

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

21 A. I could only make a guess about that.

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

1 it 20? Is it 30?

2 A. It's probably closer to 50.

3 Q. Somewhere between 30 and 50 you think?

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

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

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

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

17 MR. BLAKE: I'm sorry?

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

21 MR. BLAKE: Okay.

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

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

4 BY MR. BLAKE:

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

9 A. That's correct.

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

16 MS. INGELHART: Thank you.

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

19 BY MR. BLAKE:

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

24 A. Personal injury, correctional systems,

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

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

12 A. The latter.

13 Q. So all of these are gender -- all of
14 these you would qualify as falling -- oh, sorry.

15 So they all fall under obviously
16 your expertise in general psychology, right?

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

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

21 A. That's correct.

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

1 for gender and gender diversity, right?

2 A. Correct.

3 Q. What portion of these cases, these 30 to
4 50 cases and these roughly eight different areas
5 would you say fall primarily under your expertise
6 in gender and gender diversity?

7 A. I would be offering a guesstimate at
8 best.

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

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

13 Q. Sure.

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

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

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

24 Q. Okay. What about your cases dealing

1 with correctional institutes?

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

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

6 A. Yes.

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

9 A. Primarily.

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

12 A. Yes.

13 Q. Gender and gender diversity issues in
14 those cases?

15 A. Yes.

16 Q. How many of those cases have you done?

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

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

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

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

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

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

6 A. Yes. And perhaps that's all.

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

9 A. I did not.

10 Q. What about in the Puerto Rico case?

11 A. No.

12 Q. What about in the Michigan case?

13 A. No.

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

17 A. Yes.

18 MS. INGELHART: Excuse me.

19 MR. BLAKE: Hold on a second.

20 MS. INGELHART: Okay.

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

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

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

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

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

15 MS. INGELHART: Thank you.

16 BY MR. BLAKE:

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

19 A. Some are and some aren't.

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

1 cases?

2 A. Would you repeat that question?

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

10 A. PTSD or trauma.

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

14 A. Some. The majority did not.

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

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

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

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

1 correct?

2 A. Correct.

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

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

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

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

13 Q. Okay.

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

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

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

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

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

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

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

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

3 A. Correct.

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

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

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

17 A. It was a gender affirming procedure.

18 Q. Gender affirming procedure, okay.

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

23 A. No.

24 Q. Okay.

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

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

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

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

18 A. Yes.

19 Q. What are the nature of those cases?

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

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

1 A. Yes.

2 Q. Approximately how many?

3 A. Approximately three.

4 Q. Are you plaintiff? Do you represent the
5 plaintiff or an expert for the plaintiff or the
6 defendant?

7 A. Plaintiff.

8 Q. And are they cases against government or
9 insurance companies?

10 A. Both.

11 Q. Is the general premise of those cases a
12 claim involving either refusal of coverage or
13 refusal to reimburse for various procedures
14 associated with someone's gender affirmation?

15 MS. INGELHART: I'm just going to object.
16 You know, answer to the extent you can without
17 breaching that expert attorney privilege, that work
18 product privilege.

19 BY MR. BLAKE:

20 Q. I just want to say for the record I
21 haven't asked for the names of the cases, the
22 agencies involved or the governments. I think we
23 are still at a very high level to where, you know,
24 just getting the general issues, the general claims

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

3 A. What was the question again?

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

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

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

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

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

23 A. I think that's true.

24 Q. Okay. The bathroom cases, how many of

1 those have you been involved in?

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

5 Q. So a total of four?

6 A. I think that's accurate.

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

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

11 Q. That's fine.

12 A. -- I may not be recalling accurately.

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

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

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

20 A. Six.

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

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

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

6 A. Yes.

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

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

12 A. No.

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

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

19 BY THE WITNESS:

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

1 BY MR. BLAKE:

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

5 A. Yes.

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

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

10 Q. Approximately how many times?

11 A. I have to count on my fingers.

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

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

19 Q. Understood.

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

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

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

6 A. Let's call it 48.

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

10 A. In the past ten years.

11 Q. In the past ten years.

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

15 A. No, I don't know.

16 Q. You have no idea?

17 A. I would have to make a guess.

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

20 A. Less.

21 Q. Do you think it's greater or less than
22 25 percent?

23 A. Combining those two organizations?

24 Q. Correct.

1 A. I would say less.

2 Q. Still less, okay. So a handful of times
3 you've been retained by ACLU or Lambda Legal?

4 A. Yes. Probably more by the ACLU because
5 they have offices in every state, and I've gone to
6 prisons in some of those states. I would also like
7 to amend something I said earlier.

8 Q. Is it now seven bathroom and locker room
9 cases?

10 A. No. There's an immigration case in
11 there.

12 Q. Okay. Immigration. Did that involve
13 gender and gender diversity issues?

14 A. Yes.

15 Q. How?

16 A. A transgender person was seeking asylum
17 in the United States.

18 Q. Okay. And how did the transgender --
19 how did their gender identity have any impact on
20 whether or not they were entitled to asylum?

21 A. They were being persecuted in their
22 country of origin, and the other transgender people
23 they had been associating with had been killed or
24 threatened, and they were told that if they weren't

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

4 Q. Were they granted asylum?

5 A. Yes.

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

7 You mentioned one medical mal case
8 where you were retained by the defendant. Of those
9 48 cases or so over the last ten years, how many
10 times have you been retained by defense counsel?

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

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

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

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

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

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

4 Q. Yes.

5 A. Yes.

6 Q. Thank you.

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

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

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

18 A. Correct.

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

22 A. Yes.

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

1 called as a testifying expert?

2 A. By testifying, are you --

3 Q. An expert that would be disclosed.

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

5 Q. You were disclosed in all 48?

6 A. Yes, but I didn't offer testimony in all
7 48.

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

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

13 Q. So had those cases gone to trial, those
14 48, you would have testified at some point, likely
15 your deposition would have been taken or you would
16 have been called as a witness or something like
17 that, right?

18 A. Correct.

19 Q. At least that was your understanding?

20 A. That was my understanding.

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

1 opportunity to testify or were you just a
2 consultant?

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

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

9 A. Probably both.

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

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

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

17 A. No.

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

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

24 Q. Okay. So never a case like this one

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

3 A. Right.

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

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

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

12 A. To a law?

13 Q. Yes.

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

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

22 A. Yes.

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

1 involving a challenge to a governmental regulation?

2 A. Presently, yes.

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

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

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

14 A. Yes.

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

19 A. I believe so.

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

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

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

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

9 A. Many, many do.

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

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

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

21 A. Right. And the Graham Grimm.

22 Q. I think you're right, Grimm.

23 A. Graham?

24 Q. I think Grimm was the plaintiff.

1 MS. INGELHART: Gavin.

2 MR. BLAKE: Gavin Grimm.

3 THE WITNESS: Gavin Grimm, that case.

4 And the immigration case was against the
5 government.

6 BY MR. BLAKE:

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

12 A. I've been a court appointed expert.

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

15 A. In Sania versus Turko.

16 Q. What did that case --

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

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

21 A. No.

22 Q. How many court appointed cases have you
23 had?

24 A. I think that was the only time that the

1 court actually appointed me as an expert.

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

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

10 BY THE WITNESS:

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

13 BY MR. BLAKE:

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

16 A. Massachusetts.

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

19 A. Yes.

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

22 A. Plaintiff.

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

1 A. Correct, Department of Corrections.

2 Q. And how did you get called as a -- how
3 did you get appointed by the court?

4 A. The experts that had been previously
5 testifying in the case had been going back and
6 forth for approximately ten years and the judge
7 determined that it was time to bring in an
8 independent expert.

9 Q. So you were like the tie breaker?

10 A. I was the tie breaker but then
11 unfortunately the judge retired and so the case
12 went back to the beginning, but then a new firm
13 hired me since I had experience with the plaintiff
14 who constantly needed to be evaluated.

15 I'm going to ask for a brief break,
16 and I'm going to ask if someone would refill my
17 water.

18 Q. Sure.

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

21 MR. BLAKE: Back on the record.

22 BY MR. BLAKE:

23 Q. Just to recap, the only case where
24 you've represented a government entity is this

1 Massachusetts case involving the corrections
2 issues, right?

3 A. No.

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

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

10 Q. You weren't?

11 A. No. I was appointed by the court.

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

14 A. Independent.

15 Q. Special master, does that ring a bell?

16 A. No.

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

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

21 A. No.

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

1 liable or in the wrong; is that accurate?

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

5 BY THE WITNESS:

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

9 BY MR. BLAKE:

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

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

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

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

1 Q. To prevail?

2 A. Uh-huh.

3 Q. Have any of the cases where you've
4 refused to be an expert for the plaintiff, have any
5 of those cases involved a government defendant?

6 A. I don't know.

7 Q. You can't recall any?

8 A. I can't recall.

9 Q. Have any of the cases where you've
10 refused to be an expert for the plaintiff involve
11 transgender issues?

12 A. Yes.

13 Q. Do you know approximately how many
14 times?

15 A. I know at least two or three times.

16 Q. Did any of those cases involve -- Well,
17 can you tell me what category of cases those
18 involved? Were they PI cases, correction cases,
19 discrimination cases?

20 A. They were correction cases and PI
21 cases.

22 Q. You've rendered an opinion in this case,
23 right?

24 A. Yes.

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

6 A. Yes.

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

10 A. Yes.

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

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

16 MR. BLAKE: I will retract the question.
17 BY MR. BLAKE:

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

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

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

24 A. I produced a report in this case.

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

3 A. Yes.

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

6 A. Yes.

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

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

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

18 A. Not offhand I do not.

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

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

23 BY MR. BLAKE:

24 Q. What has just been handed to you has

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

7 A. Yes.

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

17 A. I understand.

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

23 A. Yes.

24 Q. And you can leaf through this exhibit

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

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

7 Q. Paragraph 11?

8 A. Correct.

9 Q. On Page 3?

10 A. Yes.

11 Q. Okay.

12 A. I've also lectured in South America.

13 Q. Very good. Anything else?

14 A. The rest is accurate as it is.

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

20 A. Yes.

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

1 A. I'm there.

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

5 A. Approximately.

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

8 A. Yes.

9 Q. Others were written by different people,
10 correct?

11 A. Correct.

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

17 A. Correct.

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

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

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

4 A. Depending on the course.

5 Q. Depending on the course?

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

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

11 A. Correct.

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

16 A. Absolutely.

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

21 A. I do.

22 Q. Why these four?

23 A. Specifically the books that I've
24 authored?

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

5 A. No.

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

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

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

22 Q. Okay.

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

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

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

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

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

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

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

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

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

8 Q. They use --

9 A. Gender dysphoria.

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

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

15 Q. Oh, it's actually a --

16 A. There's a conceptual difference.

17 Q. It's a different diagnosis?

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

20 Q. Does the DSM-5 contain both?

21 A. No.

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

24 A. I do.

1 Q. Go ahead.

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

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

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

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

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

24 MS. INGELHART: Objection, vague, but you

1 can answer.

2 BY THE WITNESS:

3 A. I would look through them if you'll give
4 me permission.

5 BY MR. BLAKE:

6 Q. Sure. Yeah. I asked the question.

7 A. Yes, I reviewed the DSM-5 which is on
8 Page 1. And if you're asking specifically for this
9 deposition, Principles of Transgender Medicine and
10 Surgery, the second edition.

11 Q. Sorry. Which one is that?

12 A. That's on Page 2.

13 Q. Let me see if I can find that one.

14 A. It's under Ettner.

15 Q. Oh, got it. That's the MRI study one,
16 right?

17 A. That's part of what is contained in that
18 book. It's a textbook that contains --

19 Q. A lot of material?

20 A. -- a lot of material.

21 Q. All right. So before we move onto the
22 next one, what in -- Well, actually let's just
23 finish what you're doing and we'll go through each
24 of those.

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

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

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

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

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

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

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

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

8 A. Correct.

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

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

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

16 A. Is to the twins studies.

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

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

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

6 Q. That's the conclusion of Diamond?

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

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

13 A. As a footnote.

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

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

21 Q. I'm looking at --

22 A. Diamond studies.

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

1 A. Gomez-Gil, yes.

2 Q. "Familiarity of Gender Identity Disorder
3 in Non-Twin Siblings," is that the one you're
4 referring to?

5 A. That's one of the groups that has done
6 that work. Also Richard Green did that work as
7 well.

8 Q. On Page 3, Richard Green, "Family
9 Co-Occurrence of Gender Dysphoria: Ten siblings of
10 Parent-Child Pairs." Those are the ones?

11 A. Those are the ones I've listed, uh-huh.

12 Q. Those are the ones that --

13 A. I'm most familiar with.

14 Q. -- that you're most familiar with?

15 A. Yes.

16 Q. And probably based on the date of
17 publication for the DSM-5, the Gomez-Gil and the
18 Green studies would have been available at the time
19 of publication, right?

20 A. Oh, yes.

21 Q. The Diamond study, it's hard to tell,
22 but they appear to have been published in the same
23 year as the DSM so maybe less so the Diamond study,
24 but certainly Gomez-Gil and Green were available,

1 right?

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

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

10 A. I have provided that expert opinion.

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

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

15 Q. Because you're not a --

16 A. Geneticist.

17 Q. You're not a geneticist, right?

18 A. Correct.

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

23 A. Yes.

24 Q. Before we get into that, what parts of

1 the Principles of Transgender Medicine and Surgery
2 did you review?

3 A. The first chapter.

4 Q. What does that relate to?

5 A. Theories of the etiology of gender
6 dysphoria.

7 Q. Is that the chapter that you authored?

8 A. With a colleague, co-authored.

9 Q. And what is etiology?

10 A. Origin.

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

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

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

20 A. Correct.

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

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

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

3 Q. Dr. Van Meter?

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

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

8 A. No.

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

11 A. No.

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

15 A. No.

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

18 A. No.

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

22 A. I have not.

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

1 you've listed today?

2 A. No.

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

7 A. Since rendering this opinion?

8 Q. Yes.

9 A. Yes.

10 Q. Okay. What else have you reviewed?

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

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

17 A. Correct.

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

23 A. Yes.

24 Q. Okay. Anything else?

1 A. No.

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

6 A. Yes.

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

13 Is your CV still true and accurate?

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

16 Q. Okay.

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

19 Q. All right. Which one is that?

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

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

1 A. They met in the summer in Miami.

2 Q. Well, it's always Miami.

3 What was the title of that
4 presentation?

5 A. "The Transgender Patient."

6 Q. And I take it that that presentation was
7 mostly dedicated to the specific procedures that
8 plastic surgeons are involved in when someone is
9 doing their gender affirmation surgery, right?

10 A. Yes.

11 Q. That makes sense.

12 Just looking at the top block of
13 information here, positions held and I guess
14 clinical and professional experience, together that
15 forms I think what we can loosely call your
16 employment experience, right?

17 A. Yes.

18 Q. You've never worked as a medical doctor,
19 right?

20 A. Pardon me?

21 Q. You have never worked as a medical
22 doctor?

23 A. I am not a medical doctor.

24 Q. And like you said before, you don't have

1 any expertise as a molecular geneticist, right?

2 A. Correct.

3 Q. And you don't have any experience as an
4 endocrinologist, right?

5 A. I have experience with endocrinology. I
6 am not an endocrinologist.

7 Q. Right. Your husband is, right?

8 A. No.

9 Q. No, he's not?

10 A. No.

11 Q. I'm sorry. You're married, right?

12 A. Yes.

13 Q. Okay. I just noticed that your --

14 A. My husband is a primary care physician.

15 Q. Ahh, he's a primary care physician. You
16 had written an article with him, right?

17 A. Yes.

18 Q. Okay. I just -- I guess I misunderstood
19 when I looked him up what his job was. Fair
20 enough.

21 So he's not an endocrinologist
22 either, right?

23 A. No.

24 Q. We talked before about your areas of

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

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

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

13 A. Correct.

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

17 A. It says Global Education Initiative
18 Committee.

19 Q. Okay. That's the --

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

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

1 certification?

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

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

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

16 A. Correct.

17 Q. You obviously have received a
18 certificate?

19 A. Yes.

20 Q. The certificate is issued by this
21 committee --

22 A. By the organization.

23 Q. And the organization is WPATH?

24 A. Yes.

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

3 A. Yes. Yes, that's correct.

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

6 A. On the actual committee?

7 Q. Yes.

8 A. Let me count on my fingers now.

9 Q. Okay.

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

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

19 A. Specialists in each particular area.

20 Q. Are they all committee members?

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

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

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

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

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

13 Q. What is a GEI?

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

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

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

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

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

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

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

15 Q. The host of gender identity issues?

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

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

21 A. Correct.

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

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

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

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

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

15 A. That's correct.

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

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

1 grant CE credit.

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

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

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

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

16 A. I'm there.

17 Q. Are these still current?

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

21 Q. Better get on that.

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

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

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

5 Q. Oh, okay. That's fun.

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

8 A. Receive payment for those appearances.

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

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

14 Q. Is it like a union thing?

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

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

20 A. Okay.

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

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

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

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

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

10 A. Correct.

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

13 A. Yes.

14 Q. What are the qualifications?

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

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

3 A. Yes, we have a legal committee.

4 Q. What about teachers?

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

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

13 A. I don't know.

14 Q. You don't know?

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

18 Q. But they are sociologists or something,
19 right?

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

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

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

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

6 Q. APATH? Don't know?

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

9 Q. LAPATH?

10 A. There's a USPATH.

11 Q. USPATH?

12 A. Which is strictly United States members.

13 Q. Okay. And it's interdisciplinary?

14 A. Interdisciplinary.

15 Q. Okay.

16 A. We say multi disciplinary.

17 Q. Why?

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

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

23 A. Yes.

24 Q. What is your position?

1 A. I'm the secretary.

2 Q. What about the USPATH --

3 A. No.

4 Q. Okay. Are you affiliated with the
5 USPATH?

6 A. By virtue of being a member of WPATH,
7 I'm a member of USPATH.

8 Q. The World Professional Association For
9 Transgender Health is an advocacy group, right?

10 A. No.

11 Q. It's not?

12 A. It is not.

13 Q. You don't consider what WPATH does to be
14 an advocacy group or advocacy work?

15 A. We consider WPATH to be a professional
16 association.

17 Q. Okay. Would you consider at least an
18 element of what they do to be advocacy?

19 A. I can speak for myself in that I'm
20 advocating for a condition which I believe is the
21 most misunderstood condition in human behavior, but
22 I'm not advocating for an individual. I'm
23 advocating for education about the condition.

24 But I imagine there are people who

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

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

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

12 BY THE WITNESS:

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

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

18 (WHEREUPON, discussion was had
19 off the record.)

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

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

1 misconception.

2 MR. BLAKE: Okay.

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

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

15 BY MR. BLAKE:

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

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

20 Q. No, but thank you for the clarification.
21 Psychologists can't prescribe or
22 administer hormones, right?

23 A. Right.

24 MR. BLAKE: This is going to be

1 Defendant's Exhibit 12.

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

4 BY MR. BLAKE:

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

8 A. Yes.

9 Q. What is it?

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

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

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

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

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

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

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

1 best of your ability.

2 BY THE WITNESS:

3 A. I endorse the standards of care. The
4 rationale for revising the standards of care is
5 that certain aspects of this may be a little behind
6 the times or they may need to be refined based on
7 our current cultural and research.

8 BY MR. BLAKE:

9 Q. I think I understand.

10 A. In general though, yes, I subscribe and
11 I support the standards of care.

12 Q. There's a Version 8 coming out and
13 presumably Version 8 is going to modify in some
14 respect Version 7?

15 A. Correct.

16 Q. To the extent that Version 8 is
17 modifying Version 7, you have a different
18 understanding now and that's in the process of
19 being flushed out, right?

20 A. Most of the changes will be modest.
21 There's not going to be any major changes.

22 Q. When do you anticipate that volume,
23 Volume 8, being published?

24 A. Not before next year, 2020.

1 Q. Sometime in 2020?

2 A. We hope to debut it at our next
3 international symposium in November of 2020, but
4 that may be wishful thinking.

5 Q. So maybe not even in 2020 at all, it
6 could be 2021?

7 A. I imagine it will be 2020.

8 Q. Okay. If you would turn to Page 31 of
9 this document, let me know when you're there.

10 A. Are these pages numbered?

11 Q. On the bottom right-hand corner there
12 are page numbers.

13 A. I see it. Okay.

14 Q. At the very bottom, you'll see a caption
15 that says other tasks of mental health
16 professionals. Do you see that?

17 A. On the bottom of Page 31?

18 Q. Yes.

19 A. Yes.

20 Q. Okay. And the first numeral says,
21 "educate and advocate on behalf of clients within
22 their community, schools, workplaces, other
23 organizations and assist clients with making
24 changes in identity documents." Do you see that?

1 A. Uh-huh.

2 Q. So one of the standards of care or one
3 of the directives of the standard of care is to
4 have mental health professionals advocate on behalf
5 of transgender individuals to help them change
6 their identity documents, right?

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

9 BY THE WITNESS:

10 A. That's what it says, yes.

11 BY MR. BLAKE:

12 Q. You can put that aside for a minute.
13 You are also affiliated obviously
14 with the American Psychological Association?

15 A. I'm a member, yes.

16 Q. And it's fair to say that not just
17 anyone can be a member of the American
18 Psychological Association, right?

19 A. Correct.

20 Q. In fact, you need a Ph.D. in psychology
21 to join, right?

22 A. That I don't know.

23 Q. Do you know if you have a masters
24 degree, is that enough to be a full member of the

1 American Psychological Association?

2 A. I don't know.

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

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

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

10 A. Yes.

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

13 A. I don't know.

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

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

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

21 A. Yes.

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

24 A. Not all my publications are relevant to

1 this report, correct.

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

5 A. Correct.

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

9 A. I suppose.

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

13 A. Beginning with presentations?

14 Q. Yes, please.

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

18 Q. Yep.

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

1 Q. Okay.

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

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

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

16 A. In the American College of Legal and
17 Legal Medicine Presentation, a colleague of mine
18 who is an attorney and who's also a trans man
19 talked about discrimination and the harms that
20 occur when people who look like he does, for
21 instance, he's bald and has a full beard and he's
22 70, would have to, for example, use a female
23 bathroom, how that would be a totally untenable
24 situation.

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

3 A. Correct, the American College of Legal
4 Medicine.

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

8 A. Yes, and the harms that ensue.

9 Q. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Of course, Gender Loving Care: A

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

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

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

10 A. Yes.

11 Q. Which ones?

12 A. "Etiology of Gender Dysphoria."

13 Q. That's a writing?

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

15 Q. Publication on Page 5?

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

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

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

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

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

13 A. Which of these publications?

14 Q. Yes.

15 MS. INGELHART: Objection, vague and
16 possibly speculation, possibly. You can answer.
17 BY THE WITNESS:

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

22 BY MR. BLAKE:

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

24 A. Okay.

1 Q. Your publications.

2 A. My publications.

3 Q. Yes. That deal with the biologic basis,
4 if any.

5 MS. INGELHART: Objection. Just like in
6 our prior depositions with the clients, there's --
7 I would like to object to terms that could be terms
8 of art are at issue in this case, so biological may
9 be one of those terms. Thank you.

10 THE WITNESS: Right. I don't know that I
11 would use the term biological as opposed to social
12 as a lay person kind of distinction. I mean, we
13 wouldn't say biological. We would say, you know,
14 neurocortical or neurophysiologic, but whatever.
15 Let's keep it simple.

16 BY MR. BLAKE:

17 Q. If you look at Page 6 of your expert
18 report, Paragraph 25, you say, "a growing
19 assemblage of research documents that gender
20 identity" --

21 A. "Is immutable."

22 Q. "And biologically based."

23 A. Uh-huh.

24 Q. So I already asked you about the

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

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

9 Q. I would.

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

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

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

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

6 In the Guillamon, in the next
7 "Current Opinion in Endocrinology and Diabetes,"
8 some of that will be repeated in there. In the
9 2015 "Etiopathic Hypothesis on Transsexualism,"
10 that will have some, slightly less because it's an
11 earlier work, but the 2017 -- the 2016 will have --
12 and 2017 will have more of the latest information,
13 although there's more since then which a simple
14 literature review would reveal.

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

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

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

20 A. Yes.

21 Q. Okay.

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

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

3 Q. Understood.

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

9 A. More current.

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

13 A. No, 2016.

14 Q. Okay.

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

19 Q. Are those all?

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

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

24 A. Antonio Guillamon.

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

3 A. FMRI.

4 Q. FMRI.

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

7 Q. Is he a neurologist?

8 A. He's a neuropsychologist.

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

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

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

17 (WHEREUPON, discussion was had
18 off the record.)

19 BY MR. BLAKE:

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

22 A. Correct.

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

1 A. Yes.

2 Q. You've read the literature, some of the
3 literature at least, correct?

4 A. Yes. And my research partner, Dr. Tanya
5 White, is a -- also does magnetic -- brain imaging
6 in the Netherlands.

7 Q. To the extent that you've written about
8 that topic, has it always been in partnership with
9 someone who has expertise or specialization in
10 neuropsychology?

11 A. To the extent that I have published
12 their results, yes, it has always been in
13 collaboration with them.

14 Q. And is your expert opinion in this case
15 in any way -- Strike that.

16 Are you offering an expert opinion
17 in this case based on some analysis or
18 understanding of neuropsychology?

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

21 BY THE WITNESS:

22 A. No.

23 BY MR. BLAKE:

24 Q. And you wouldn't consider yourself an

1 expert in that field, right?

2 A. Correct.

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

5 A. Yes.

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

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

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

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

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

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

1 of sex steroids on the brain.

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

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

19 Q. I'm sure it does.

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

22 Q. Not too much further I hope.

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

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

5 Q. You get one?

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

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

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

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

19 Q. Yeah, I don't --

20 A. You don't want to go there.

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

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

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

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

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

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

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

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

19 Q. Sure.

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

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

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

11 Q. What page are on?

12 A. I'm on Page 4 now.

13 Q. Of the bibliography?

14 A. Yes. If you look at the middle of the
15 page where it says Schneider, "Typical Female
16 2nd-4th Finger Length (2D:4D) Ratios in
17 Male-to-Female Transsexual-Possible Implications
18 For Prenatal Androgen Exposure," there's a wealth
19 of information about this 2D:4D digit length, and
20 in infants that died prior to birth, when they've
21 looked at it, they've already seen this ratio, so
22 we know this is something that has do with prenatal
23 hormones because it's present prior to birth.

24 So there's a wealth of research. If

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

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

11 Q. Can you tell me what that is?

12 A. I'll leave it there.

13 Q. Why is that relevant?

14 A. Because it's lunchtime.

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

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

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

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

13 A. Hormones, correct.

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

16 A. Correct.

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

20 A. Well, what they're --

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

24 A. No.

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

3 BY MR. BLAKE:

4 Q. Please.

5 A. Yes. No. What they found -- So I have
6 to back up a bit. On autopsy when Zhou in the year
7 2000, Z-h-o-u, in the Netherlands found on autopsy
8 that people who were transsexual had a different
9 brain structure than people who weren't, the New
10 York Times heralded that and said what transsexuals
11 have been saying all along is true, that their
12 brain is female, you know.

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

16 Q. Right.

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

19 Q. Understood.

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

24 A transgender woman's, you would see

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

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

12 Q. I think I understand. I do.

13 A. I think you do.

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

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

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

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

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

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

14 MS. INGELHART: Great.

15 (WHEREUPON, a lunch break was
16 taken.)

17 MR. BLAKE: Back on the record.

18 BY MR. BLAKE:

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

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

24 Q. 5, yes.

1 A. Yes.

2 Q. And that lists several cases which over
3 the last four years you've testified as an expert
4 at trial or by deposition, right?

5 A. Correct.

6 Q. Okay. Broussard v. First Tower Loan.
7 That's the first case you've listed there, do you
8 see that?

9 A. Yes.

10 Q. Was that a case that involved
11 transgender individuals?

12 A. Yes.

13 Q. What was the issue in that case?

14 A. This was a case concerning a young man
15 who applied for a job and he was a trans man and he
16 was in his first week of work and doing
17 exceptionally well, and his boss was very pleased
18 with him, and she asked to see an identity document
19 of his.

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

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

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

11 Q. That was an employment discrimination
12 case?

13 A. Yes.

14 Q. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

4 A. Yes.

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

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

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

10 A. No.

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

14 A. Over 3,000.

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

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

21 BY THE WITNESS:

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

24

1 BY MR. BLAKE:

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

6 A. Correct.

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

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

14 BY THE WITNESS:

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

23 BY MR. BLAKE:

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

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

3 A. I am aware of people who have
4 detransitioned.

5 Q. Is that the terminology, detransitioned?

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

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

17 A. No, I have never used natal sex.

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

19 A. I use sex assigned at birth.

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

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

4 BY THE WITNESS:

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

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

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

1 birth.

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

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

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

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

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

22 A. Yes.

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

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

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

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

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

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

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

23 A. I do.

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

1 sex?

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

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

7 A. No.

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

10 A. Not solely, no.

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

13 A. No. Not entirely, no.

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

16 A. No, not necessarily.

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

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

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

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

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

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

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

1 untreated for gender dysphoria.

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

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

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

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

24 Q. So it's your testimony then that gender

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

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

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

20 A. Yes.

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

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

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

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

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

15 A. Yes. If they are adults, yes.

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

18 A. Yes. Yes.

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

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

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

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

3 Q. It's easy for them?

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

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

10 A. If any time thinking about it.

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

13 A. No.

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

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

21 A. Correct.

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

1 A. Yes.

2 Q. Is it your understanding that that
3 record is made at or near the time of birth?

4 A. Yes.

5 Q. Do you have any opinion on whether or
6 not the State has value in recording an
7 individual's sex at birth?

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

10 BY THE WITNESS:

11 A. I don't have any opinion about that.

12 BY MR. BLAKE:

13 Q. You don't have an opinion one way or the
14 other?

15 A. I mean, I believe that it's common in
16 that it's important to have some vital statistics
17 on our citizens.

18 Q. I mean, like, for example, the way in
19 which information is compiled on birth weight for a
20 particular sex, right?

21 A. Correct.

22 Q. When a person is born, do you have a
23 general understanding of how the sex of that
24 individual is determined?

1 A. Yes.

2 Q. What is that understanding?

3 A. A cursory examination of the external
4 genitalia.

5 Q. When you say cursory, do you think there
6 should be a more extensive review of a person's
7 genitalia before a medical provider determines male
8 or female?

9 MS. INGELHART: Objection, calls for
10 speculation. You can answer.

11 BY THE WITNESS:

12 A. Well, I've been at many births and I've
13 seen where a midwife will see the external
14 genitalia and will announce the birth of the -- the
15 sex of the child based on that.

16 BY MR. BLAKE:

17 Q. And in your opinion that's cursory. You
18 said cursory.

19 A. Right. It's based on a physical of how
20 the genitals appear at the time of birth. There's
21 no internal exam done. There's no ultrasound done.
22 It's just a look and see.

23 Q. Do you have an expert opinion on whether
24 or not it would be appropriate for a medical

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

4 A. Not at the time of birth.

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

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

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

17 A. Correct.

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

21 A. Yes. Sex assigned at birth.

22 Q. Sex assigned at birth, sure.

23 A. Yes.

24 MR. BLAKE: We'll do Exhibit 13.

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

3 BY MR. BLAKE:

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

9 A. Yes.

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

13 A. Correct.

14 Q. But we understand is synonymous with
15 gender dysphoria?

16 A. Yes.

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

21 A. Yes.

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

1 A. That I hadn't used today.

2 Q. Oh, okay. Not ever in the history of
3 your writing.

4 A. Historically we used to talk -- we used
5 to use natal sex or some people would say genetic
6 sex, and we have moved away from that.

7 Q. But those are terms that we use or I
8 bring it up in your writing, you understand what
9 that means, right?

10 A. Yes, assigned at birth, the sex assigned
11 at birth.

12 Q. So it's a terminology difference?

13 A. Correct.

14 Q. You say sex assigned at birth.

15 Previously that was referred to in some
16 circumstances as natal sex, other times genetic
17 sex, but those are synonymous, if antiquated; is
18 that accurate?

19 A. Genetic sex I don't think was something
20 that was ever really a term that professionals
21 used, but we did use natal sex.

22 Q. All right. You can put that one aside
23 for now.

24 A. It was a good article.

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

7 A. What section?

8 Q. Second page of Defendant's Exhibit 13.

9 MS. INGELHART: It's the third page.

10 BY MR. BLAKE:

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

15 A. Uh-huh.

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

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

1 of the term.

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

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

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

12 A. Those aren't phenotypes.

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

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

18 Q. It looks like 2007.

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

21 Q. You might have written it prior to that?

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

24 Q. All right.

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

3 Q. But at one point in time?

4 A. Yes. Yes.

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

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

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

14 A. Someone who has gender incongruity, yes.

15 Q. Someone who has gender incongruity.

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

18 A. It leads to a desire to transition.

19 Q. Transition from their natal sex?

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

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

24 A. Their gender identity doesn't change,

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

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

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

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

16 A. It's the incongruity.

17 Q. Between their gender identity?

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

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

23 A. Correct.

24 Q. If you look at Paragraph 16 of your

1 report, that's Defendant's Exhibit 11, on Page 5.

2 Let me know when you're there.

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

5 BY MR. BLAKE:

6 Q. Paragraph 16 on Page 5.

7 A. Yes.

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

14 A. Yes.

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

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

20 BY THE WITNESS:

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

23 BY MR. BLAKE:

24 Q. Well, you wrote in Paragraph 16 that a

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

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

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

11 A. That is not my opinion.

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

15 A. Correct.

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

19 A. Yes.

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

23 A. Yes.

24 Q. In fact, it's common for transgender

1 individuals to present at age 60 or older, right?

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

4 BY THE WITNESS:

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

6 BY MR. BLAKE:

7 Q. Sure.

8 A. To present for treatment?

9 MR. BLAKE: This is going to be 14.

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

12 BY MR. BLAKE:

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

18 A. Yes.

19 Q. You recognize this article?

20 A. I do.

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

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

2 A. Yes.

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

7 A. No.

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

10 A. Yes.

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

13 A. Yes.

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

17 A. Yes.

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

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

24 BY THE WITNESS:

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

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

17 BY MR. BLAKE:

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

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

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

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

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

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

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

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

6 So people, particularly people in
7 the prison from resource poor backgrounds, many of
8 them are in prison in their later -- at age 30 or
9 40, they learn that there is a condition and that
10 they're not the only person in the world who feels
11 this way, and prior to that they were just living
12 in the body they were born with and trying to live
13 in accordance with a sex they were assigned at
14 birth regardless of any discomfort they may have
15 felt.

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

20 A. Those arrows?

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

1 and hormonal," right?

2 A. Uh-huh.

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

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

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

9 A. They intensify dysphoria.

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

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

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

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

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

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

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

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

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

19 A. This is not gender identity.

20 Q. Okay.

21 A. This is identity.

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

1 you're there.

2 A. Yes.

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

7 A. Uh-huh.

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

10 A. Dysphoria.

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

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

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

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

1 deal with when they consider transitions at a later
2 age.

3 Q. That includes issues of gender identity,
4 right?

5 A. Yes.

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

8 A. Yes.

9 Q. Let me know when you're there.

10 A. I'm there.

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

21 A. Yes.

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

1 A. Yes.

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

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

11 Q. That's boy or girl, right?

12 A. Correct. In most cases, yes.

13 Q. In most cases?

14 A. Yes.

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

17 A. Okay.

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

20 A. Correct.

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

24 A. I'm not aware of that.

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

3 A. Choice?

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

6 A. They are assigned to one category or
7 another.

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

10 A. Yes.

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

14 A. Yes.

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

17 A. Yes.

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

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

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

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

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

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

10 BY THE WITNESS:

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

17 BY MR. BLAKE:

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

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

23 A. Yes.

24 Q. Bullet No. 4 says, "mental health

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

3 A. Yes.

4 Q. Do you agree with that statement?

5 A. Yes.

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

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

14 BY THE WITNESS:

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

17 BY MR. BLAKE:

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

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

24 BY THE WITNESS:

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

5 BY MR. BLAKE:

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

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

11 BY THE WITNESS:

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

22 BY MR. BLAKE:

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

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

4 Q. In a binary expression, right?

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

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

21 A. That's my belief, yes.

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

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

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

6 BY MR. BLAKE:

7 Q. Do you agree with that statement?

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

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

15 A. Yes.

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

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

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

6 You still agree with that statement,
7 right?

8 A. Yes.

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

10 A. No, I agree with that.

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

15 A. Yes.

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

19 A. I'm sorry, repeat that.

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

23 MS. INGELHART: Objection, speculation.

24 You can answer.

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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

1 those develop normally --

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

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

10 A. Yes.

11 Q. You would say though that external
12 genitalia are an accurate proxy for a person's
13 karyotype, right?

14 A. No.

15 Q. So in the normal case, without, you
16 know, any abnormality with external genitalia, a
17 normal phenotype, a normal genotype, lots of types,
18 if you had an external genitalia of male, wouldn't
19 that be a good indicator that they have XY
20 chromosomes?

21 A. A good indicator?

22 Q. Sure.

23 A. It's a likely indicator.

24 Q. Likely?

1 A. Not necessarily though.

2 Q. Understood, but in most cases it's going
3 to be an accurate proxy for that person's
4 chromosomes?

5 A. In most cases.

6 Q. Excluding the abnormalities that we --

7 A. Can't see.

8 Q. -- that we can't see. All right. As
9 far as you know aren't at issue in this case,
10 right?

11 A. As far as I know.

12 Q. And would you agree that most people's
13 chromosomes are consistent with the physical
14 appearance of their external genitalia?

15 MS. INGELHART: Objection, calls for
16 speculation. Again like to these -- I hope we can
17 agree we've had like a standing objection on the
18 use of these terms of art that are at issue, but
19 you can answer.

20 BY MR. BLAKE:

21 Q. That's fine. Would you agree with
22 that?

23 A. Would you repeat the question?

24 Q. Yeah. That most people's chromosomes

1 are consistent with the physical appearance of
2 their external genitalia, I mean, other physical
3 attributes.

4 A. There are many chromosomal anomalies
5 where genitalia can appear normal, however, there
6 is a chromosomal anomaly, so a person could, for
7 instance, have two Xs and a Y and have a normal
8 appearing genitalia, and we'll assume for the sake
9 of this conversation that the majority of people
10 have a primary sex characteristic or an external
11 genitalia. The majority of those people will have
12 a normal chromosomal pattern.

13 Q. Consistent with the outward physical
14 appearance?

15 A. The majority of people, right.

16 Q. Whether it's 70 percent or 95 percent or
17 99.9 percent, the normal --

18 A. Very often we're just not aware of the
19 anomalies. Without karyotyping, we don't know.

20 Q. I think this is what you just stated,
21 but in the normal sense of it, right, most people,
22 their external genitalia then would be an accurate
23 proxy for whether a person is a genetic male or
24 genetic female, right?

1 A. For most people who are assigned a sex
2 at birth, based on their genitalia, that is an
3 accurate reflection of their gender identity and
4 they are comfortable with that assigned sex.

5 Q. For those who aren't assigned sex at
6 birth, it's because there's some ambiguity or maybe
7 they're born with intersex conditions because those
8 individuals --

9 A. Or gender identity.

10 Q. Well, no one is born with gender
11 identity. I mean, we already talked about how you
12 can't identify gender identity at the time of
13 birth, right?

14 A. That doesn't mean they're not born with
15 it. It's within the brain. It's just they don't
16 express it.

17 Q. Got it. I wasn't talking about gender
18 identity.

19 A. Okay.

20 Q. I was talking about genetic male,
21 genetic female which we previously -- you know,
22 those are old terms, those are archaic terms, I get
23 that. We're talking about external genitalia and
24 their correspondence to genetic maleness or genetic

1 femaleness. For most people, it's an accurate --

2 A. It's concordant for most people.

3 Q. Let's go to Paragraph 19 in your
4 opinion, Page 5 still. Are you there?

5 A. Yes.

6 Q. All right. In that paragraph you
7 identify five components that comprise a person's
8 sex, right?

9 A. I have to count them.

10 Q. It's always a good idea to check a
11 lawyer's math. Yes?

12 A. Yes, I mention five.

13 Q. All right. Perfect. Chromosomal
14 composition, right?

15 A. Yes.

16 Q. That's the XY and the XY karyotyping we
17 have been talking about, right?

18 A. Yes, and the other types which --

19 Q. Sure.

20 A. -- could be present, right.

21 Q. XXX, XXY, whatever, right?

22 A. There's at least 35 of them.

23 Q. Okay. But in most cases, whatever it
24 is?

1 A. Right.

2 Q. Internal reproductive organs, right?

3 A. Correct.

4 Q. External genitalia, right?

5 A. Yes.

6 Q. Brain structure, right?

7 A. Yes.

8 Q. That relates to those studies that we
9 talked about before lunch, right?

10 A. Yes.

11 Q. And gender identity?

12 A. Yes.

13 Q. Okay.

14 A. Brain structure and brain development.

15 Q. Brain structure and brain development?

16 A. Yes.

17 Q. Those first four all fit into the
18 category of anatomy, right?

19 MS. INGELHART: Objection, calls for
20 speculation. You can answer.

21 BY THE WITNESS:

22 A. The first four I would say are physical
23 and can be detected.

24 BY MR. BLAKE:

1 Q. All right. So in Paragraph 21 you say,
2 "when there is divergence between anatomy and
3 identity." Do you see that, that first clause?

4 A. Yes.

5 Q. So of the five components that you list
6 there, only one is an identity component, right?

7 A. Yes.

8 Q. So the other four, correct me if I'm
9 wrong, are anatomical, right?

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

12 BY THE WITNESS:

13 A. More or less.

14 BY MR. BLAKE:

15 Q. I mean, those are your words.

16 A. Yes.

17 Q. You said there's divergence between
18 anatomy and identity. You know, chromosomal
19 composition, that's not identity, right?

20 A. Correct.

21 Q. Internal reproductive, that's not
22 identity, right?

23 A. Right.

24 Q. External genitalia, that's not identity,

1 right?

2 A. Right.

3 Q. Brain structure, brain development?

4 A. That's where identity lives.

5 Q. Is that a product of identity?

6 A. It's where identity arises.

7 Q. But you don't -- right, but you don't
8 know if that has an anatomical or -- it's
9 detectable biologically, right?

10 A. It's detectable only by imaging or
11 autopsy.

12 Q. I guess you don't know whether it's a --
13 I guess it's kind of like a chicken and the egg,
14 right? You don't know if the identity is shaping
15 the anatomy or if the anatomy is shaping the
16 identity, right?

17 MS. INGELHART: Objection, vague,
18 misstates prior testimony, mischaracterizes prior
19 testimony. You can answer.

20 BY MR. BLAKE:

21 Q. I mean, do you know?

22 A. What is the question?

23 Q. Well, the question is those brain
24 studies that we talked about, right, which shape

1 the brain, influence brain development, right?

2 A. Right. Those are there at birth.

3 Q. At birth?

4 A. Yes, and they give rise to gender
5 identity, and gender identity isn't visible, nor
6 are those microstructures at birth, and only under
7 sophisticated and rather new technology have we
8 become aware of them, but the mind is where gender
9 identity is, right? I mean --

10 Q. I don't know. You're the expert.

11 A. Well --

12 Q. I don't know.

13 A. How do you know that you're a man?
14 Where does your sense of being a man lie? I mean,
15 it's in your head. Even people who are
16 developmentally disabled, autistic or brain damaged
17 have a gender identity.

18 Q. So not every transgender person has the
19 same indicia in their brain structure, right?

20 MS. INGELHART: Objection, vague, calls
21 for speculation. You can answer.

22 BY MR. BLAKE:

23 Q. Do you know?

24 A. I don't think I understand the question.

1 Would you repeat it?

2 Q. Well, you know, you said that there's
3 these brain studies that occurred and they
4 identified some --

5 A. Four different brain phenotypes.

6 Q. Right. And that they found some
7 correlation between transgender individuals and
8 certain brain structure, right?

9 A. Not just brain structure but the brains
10 of people who are transgender differ in the same
11 way. They all differ in the same way from
12 non-transgender brains.

13 Q. That's my question is that if you were
14 to do a brain study of every single transgender
15 person on the planet, would you find that they all
16 had these difference in the same way?

17 MS. INGELHART: Objection, calls for
18 speculation.

19 MR. BLAKE: These are the conclusions
20 from the report. I mean, if the report reached
21 that conclusion, great. If it didn't --

22 MS. INGELHART: Objection,
23 mischaracterization of prior testimony. You can
24 answer.

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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 --

1 BY MR. BLAKE:

2 Q. I'm just trying to figure out where to
3 put this brain structure component. I think what
4 you're describing are anatomical things that are
5 discoverable from anatomy.

6 A. They are different in many ways.

7 Q. All right. But the structure of the
8 brain is I think by definition anatomy, right?

9 MS. INGELHART: Objection. Actually
10 maybe terms at issue. You can answer.

11 BY THE WITNESS:

12 A. I don't know if we would consider -- I
13 guess the cortex in the area of the brain, I'm not
14 an anatomist, but I would say that there are
15 different -- you know that there are different
16 areas of the brain.

17 BY MR. BLAKE:

18 Q. Of course.

19 A. And some of those areas are gray matter.
20 Some of them are white matter. Some of them are,
21 you know, the prefrontal cortex. Some of them is
22 the corpus callosum that divides the brain. So,
23 yes, the brain is a material organ.

24 Q. That can be observed, right?

1 MS. INGELHART: Can we just take a break
2 here? I think we're --

3 BY THE WITNESS:

4 A. It could be observed with imaging.

5 MS. INGELHART: I think we're going in
6 circles and I really need to go to the bathroom.

7 MR. BLAKE: I don't think we're going in
8 circles.

9 BY THE WITNESS:

10 A. It can be observed by -- certain parts
11 of it can be observed by imaging. Certain parts
12 could be observed by cutting it open and looking at
13 it.

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

16 MS. INGELHART: We are on the record.
17 You wanted to clarify one quick thing from before
18 about a couple cases or I can clarify on the
19 record.

20 MR. BLAKE: Here we go.

21 MS. INGELHART: Neither Dr. Ettner or I
22 can recall, but I'm on the papers on two cases that
23 she previously was an expert on. I honestly don't
24 know if we were ever on the same phone call but

1 it's possible.

2 MR. BLAKE: I was going to have some
3 devastating impeachment.

4 THE WITNESS: I know I've never met you
5 in person.

6 MS. INGELHART: I don't even know if on
7 the phone. I wasn't lead on those cases.

8 THE WITNESS: I don't remember your name
9 but --

10 MS. INGELHART: I didn't want you to
11 look at the papers and see my name and get
12 concerned.

13 MR. BLAKE: Dead to right. Saved
14 yourself. You're lucky.

15 THE WITNESS: That's a big load off.

16 BY MR. BLAKE:

17 Q. So if the chromosome and the composition
18 of an individual indicates male, are you with me?
19 Yes?

20 A. If it's verified as male?

21 Q. Yes.

22 A. Like by karyotyping, yes.

23 Q. So chromosomal composition, varied by
24 karyotyping, XY, male, right?

1 MS. INGELHART: Objection, hypothetical.

2 You can answer.

3 BY THE WITNESS:

4 A. That doesn't mean the gender identity is
5 male.

6 BY MR. BLAKE:

7 Q. I'm not talking about gender identity.
8 We're going to get to gender identity. So
9 chromosomal composition, XY karyotype?

10 A. Phenotype male.

11 Q. Phenotype male?

12 A. Correct.

13 Q. Internal reproductive organs consistent
14 with male, are you with me?

15 A. Yes.

16 Q. Okay. External genitalia consistent
17 with the chromosomal composition and the internal
18 reproductive organs, so also normally male?

19 A. Yes.

20 Q. Okay. Brain structure, let's say it
21 doesn't correspond with the indicia in that MRI
22 study. Are you still with me?

23 A. Yes.

24 Q. So I guess a male brain would be what

1 that would indicate, right?

2 A. That it's --

3 Q. Normal male brain?

4 A. Okay. Typical male brain, not normal.

5 Q. Typical. I get it. Gender identity
6 though identifies as female, okay? Are you with
7 me?

8 A. No because then I would say that the
9 phenotype of the brain is not typical male.

10 Q. Okay. Well, the MRI, the imaging of
11 the brain doesn't reveal any of those four indicia
12 that you have, right, pointed out in the study?

13 A. There's more than four. I've just
14 listed four for the sake of our conversation.

15 Q. The MRI, the imaging study reveals
16 typical male brain, but the gender identity of the
17 individual, you know, the person identifies as
18 female, all right? Still with me?

19 A. Is this a hypothetical that you're
20 providing?

21 Q. It is.

22 MS. INGELHART: I just want to object
23 that it's an incomplete hypothetical, but answer to
24 the best of your ability.

1 THE WITNESS: Is there a question?

2 BY MR. BLAKE:

3 Q. Yes. What is that person's sex?

4 A. I don't know.

5 Q. Okay. So if they have -- if the
6 anatomical components of a person's sex all
7 indicate one sex but the identity component
8 indicates another sex, you don't know what that
9 person's sex is?

10 A. I would say if their identity is female,
11 then their sex should be -- and they make a
12 transition to present and live in the female
13 gender, then female would be the answer to that
14 question, to that hypothetical.

15 Q. And that's what you say in 21, right,
16 "when there is divergence between anatomy and
17 identity, one's gender identity is paramount and
18 the primary determinant of an individual's sex
19 designation," right?

20 A. Yes.

21 Q. In that hypothetical and based on what
22 you've said in Paragraph 21, gender identity
23 outweighs the other four components, right?

24 A. Yes.

1 Q. So in that circumstance, there's really
2 only one factor for determining a person's sex,
3 right?

4 A. In the hypothetical that you have
5 provided.

6 Q. And that's someone's gender identity,
7 right?

8 A. Yes.

9 Q. In that circumstance, someone's anatomy
10 is less relevant?

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

13 BY THE WITNESS:

14 A. Yes. I'm not sure I agree with all of
15 the elements of your hypothetical, but I'm -- my
16 opinion is that gender identity is paramount and
17 takes precedent over anatomical or phenotypical
18 features.

19 BY MR. BLAKE:

20 Q. Well, if that hypothetical person showed
21 up to your office for a diagnosis, you certainly
22 wouldn't try to convince them to live as their
23 anatomical sex, right? That wouldn't be something
24 you would try to do during your diagnosis, right?

1 MS. INGELHART: Objection, hypothetical,
2 vague. You can answer.

3 BY THE WITNESS:

4 A. I would like to ask you to rephrase the
5 question.

6 BY MR. BLAKE:

7 Q. Sure. The person who has a divergence
8 between anatomy and identity, that person shows up
9 in your office for a diagnosis, you're not going to
10 say that their sex designation should conform to
11 their anatomy, right?

12 A. I'm not going to say that.

13 Q. It's your opinion that the nonanatomical
14 factor of gender identity is the determining factor
15 in a person's sex, right?

16 A. Yes.

17 Q. And like you've written in the past,
18 there's no test, medical or psychological, to
19 diagnose transsexualism, right?

20 A. Correct. There is no blood test or
21 physiological test. Some researchers have some
22 valid instruments that they use, but they are not
23 blood tests or urine tests or, you know, conclusive
24 physiological measurements.

1 Q. What is the scientific basis for your
2 statement that gender identity is a component of a
3 person's sex?

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

6 BY THE WITNESS:

7 A. I'm sorry, would you repeat it?

8 BY MR. BLAKE:

9 Q. Yeah. What is the scientific basis for
10 your statement that gender identity is a component
11 of a person's sex?

12 A. The scientific basis for that is that
13 the American Medical Association and other medical
14 organizations all concur that if a person's gender
15 identity is incongruous with their anatomic sex and
16 they wish to transition to living in their affirmed
17 gender, then the American Medical Association and
18 other organizations have medical protocols in
19 accordance with the standards of care to implement
20 that.

21 MR. BLAKE: This is 15.

22 (Document marked as Defendant's
23 Exhibit No. 15.)

24

1 BY MR. BLAKE:

2 Q. The American Psychological Association,
3 that's an organization to which you belong,
4 correct?

5 A. Yes.

6 Q. I'm just going to read you, this is what
7 I've just provided as Defendant's Exhibit 15, which
8 is a printout from their web page, and specifically
9 a frequently asked questions section.

10 At the bottom, the drop down menu
11 says, "what is the difference between sex and
12 gender?" Do you see that? Sorry, it's at the
13 bottom of Page 1. Do you see?

14 A. I don't see that.

15 Q. There's a box at the bottom.

16 A. Oh, yes, I do see that. I'm sorry.

17 Q. And it says, "sex assigned at birth
18 refers to one's biological status as either male or
19 female and is associated primarily with physical
20 attributes such as chromosomes, hormone prevalence
21 and external and internal anatomy." Do you see
22 that?

23 A. Yes.

24 Q. And it goes on and it says, "gender

1 refers to the socially constructed roles,
2 behaviors, activities and attributes that a given
3 society considers appropriate for boys and men or
4 girls and women." Do you see that?

5 A. Yes.

6 Q. "These influence the ways that people
7 act, interact and feel about themselves. While
8 aspects of biological sex are similar across
9 different cultures, aspects of gender may differ."
10 Do you see that?

11 A. Yes.

12 Q. When the APA wrote that, they refer to
13 sex as a biological status associated primarily
14 with physical attributes. They didn't say physical
15 attributes and gender identity, right?

16 A. Correct.

17 Q. Do you agree with that statement by the
18 APA?

19 A. I agree with the statement that
20 gender -- when they're referring to gender roles
21 and gender presentation. I think that differs from
22 gender identity. They're talking about gender
23 expression.

24 Q. So you would agree that gender

1 expression does not play a role in a person's sex?

2 MS. INGELHART: Objection, misstates and
3 mischaracterizes prior testimony.

4 BY THE WITNESS:

5 A. No, I wouldn't agree with the statement
6 you've made.

7 BY MR. BLAKE:

8 Q. Do you agree that that the APA has not
9 identified gender identity as being associated with
10 sex in this statement?

11 MS. INGELHART: Objection, speculative
12 and misstates prior testimony, mischaracterizes.
13 You can answer.

14 BY THE WITNESS:

15 A. If I look further up, I see a sentence
16 that says "gender identity refers to a person's
17 internal sense of being male, female or something
18 else. Gender expression refers to the way a person
19 communicates gender identity to others through
20 behavior, clothing, hairstyle, voice or body
21 characteristics." I agree with that statement.

22 BY MR. BLAKE:

23 Q. You agree with that statement?

24 A. Yes.

1 Q. And you agree that sex, what the APA
2 says here is that "sex is assigned at birth and
3 refers to one's biological status as either male or
4 female." You agree with that?

5 A. Yes.

6 Q. You recognize the distinction between
7 sex and gender, right?

8 MS. INGELHART: Objection, terms at
9 issue. You can answer.

10 BY THE WITNESS:

11 A. I recognize a distinction between sex
12 and gender identity.

13 (Document marked as Defendant's
14 Exhibit No. 16.)

15 Q. The document you've just been handed has
16 been marked as Defendant's 16.

17 A. Yes.

18 Q. This is an article titled "Adaptation
19 and Adjustment in Children of Transsexual Parents."

20 A. Yes.

21 Q. And you are listed as one of the
22 co-authors on this article. Do you see that?

23 A. Yes.

24 Q. Do you recognize this article?

1 A. I do.

2 Q. If you turn to the second page
3 underneath the caption "methods and subjects," let
4 me know when you're there.

5 A. I'm there.

6 Q. The first sentence says, "information
7 was obtained from 27 parents with a history of TS
8 who have undergone a transition to the opposite
9 biological sex." Do you see that?

10 A. Yes.

11 Q. You wrote that, right, you or one of
12 your co-authors?

13 A. Pardon me?

14 Q. You or one of your co-authors wrote
15 that?

16 A. My co-author wrote this.

17 Q. Do you agree with that statement?

18 A. I agree with the statement that they
19 have undergone a transition, yes.

20 Q. You didn't state that those parents
21 underwent a transition to the opposite biological
22 gender, right?

23 A. She did not write that. She wrote
24 opposite biological sex.

1 Q. That wouldn't make sense. A person
2 doesn't transition to the opposite biological
3 gender, do they?

4 MS. INGELHART: Objection, terms at
5 issue. You can answer.

6 BY THE WITNESS:

7 A. They transition to their affirmed
8 gender, to another gender, to the opposite gender.
9 We wouldn't now I don't think say to the opposite
10 biological sex. I wouldn't have written that, and
11 I wouldn't write that now. I certainly understand
12 what the intention of what the meaning is and I
13 definitely agree with that.

14 BY MR. BLAKE:

15 Q. You wouldn't write transition to the
16 opposite biological gender because sex is
17 biological, like the APA says, right?

18 A. I would write that they have undergone a
19 gender transition.

20 Q. A person transitions to the opposite
21 biological sex in order to bring his or her sex
22 into alignment with their gender identity, right?

23 MS. INGELHART: Objection, terms at
24 issue. You can answer.

1 BY THE WITNESS:

2 A. Is that something that you are reading
3 from?

4 BY MR. BLAKE:

5 Q. No, it's a question. It's just a
6 question.

7 A. What is the question?

8 Q. A person transitions to the opposite
9 biological sex in order to bring his or her sex
10 into alignment with their gender identity, right?

11 A. I wouldn't phrase it that way, but I
12 think I understand what you're saying, and I agree
13 with the concept, but I would phrase it
14 differently.

15 Q. Is there a phrase or there's no such
16 thing as biological gender identity, right?

17 MS. INGELHART: Objection, terms of the
18 issue. You can answer.

19 BY THE WITNESS:

20 A. A person transitions from the sex which
21 they were assigned at birth to their affirmed
22 gender or to live in a gender other than the one
23 that they were assigned at birth.

24

1 BY MR. BLAKE:

2 Q. Have you ever used in any writing or
3 presentation the term biological gender identity?

4 A. It doesn't sound like something I have
5 written or said, but as I sit here now, I can't
6 recall everything that I've ever said or read or
7 written.

8 Q. I'm not going to pull a document that
9 says biological gender identity if that's what
10 you're worried about.

11 A. No. No. It doesn't sound like anything
12 that I or my colleagues have ever spoken.

13 Q. It doesn't make sense, does it?

14 A. Not really.

15 Q. Another interesting article, by the
16 way.

17 A. Thank you.

18 MR. BLAKE: 17.

19 (Document marked as Defendant's
20 Exhibit No. 17.)

21 THE WITNESS: Boy, I'm prolific, aren't
22 I?

23 BY MR. BLAKE:

24 Q. You know, I must say you've

1 identified -- part of the reason why we went
2 through the sort of song and dance in the beginning
3 of the deposition for you to sort of point out for
4 me was not to test your knowledge but to frankly
5 educate myself.

6 Now I have, to the extent that
7 there's not overlap, and there's some, I have more
8 reading. I have more homework. I mean, I couldn't
9 read, you know, a hundred articles. I just
10 couldn't do it. Anyways, you've given me some
11 homework.

12 All right. So I've just handed you
13 what has been marked as Defendant's 17, and it is
14 an article entitled "Disclosure of Risks and
15 Protective Factors for Children Whose Parents Are
16 Undergoing a Gender Transition." This is another
17 article co-authored by you, right?

18 A. Yes.

19 Q. You recognize this article?

20 A. I do.

21 Q. All right. If you turn to the second
22 page, the first paragraph is entitled introduction,
23 and it looks like the third sentence in that
24 paragraph which begins "the diagnostic and

1 statistical manual, 4th Edition, DSM-4 defines GID
2 in adolescence and adults as a persistent desire to
3 live as a member of the other sex." Do you see
4 that?

5 A. No. What page are you on?

6 Q. I'm on the second page in the
7 introduction.

8 A. Okay. Yes. Yes.

9 Q. All right. The third sentence begins,
10 "the diagnostic and statistical manner," do you see
11 that?

12 A. Yes.

13 Q. It goes on and says, "4th Edition, DSM-4
14 defines GID in adolescence and adults as a
15 persistent desire to live as a member of the other
16 sex." Do you see that?

17 A. Yes.

18 Q. Now, I understand that the DSM-4 has now
19 been superseded by the DSM-5, right?

20 A. Yes.

21 Q. And the term GID is no longer used, they
22 use gender dysphoria, right?

23 A. Yes.

24 Q. And they use certain criteria and

1 indicia of those two diagnoses which in your mind
2 differ, you know, not in substantial ways, right?

3 A. Not just in my mind.

4 Q. In everyone's mind.

5 A. Correct.

6 Q. Or at least the folks at the APA.

7 A. Which is the reason why it was changed,
8 yes.

9 Q. Which is the reason why it was changed
10 in the DSM?

11 A. Correct.

12 Q. Fair enough.

13 The question I have for you though
14 is at the time you and your co-author wrote that --
15 well, what you didn't write, sorry, that
16 transgender people have a persistent desire to live
17 as a member of the other gender, right?

18 A. Correct.

19 Q. That's because gender and sex in this
20 context are different, right?

21 MS. INGELHART: Objection, terms at
22 issue. You can answer.

23 BY THE WITNESS:

24 A. Again Tanya White wrote this article.

1 We did the data collection together, and the
2 writing is hers, and we -- I don't know if back
3 then it would have occurred to her to phrase it in
4 the way you're saying, but what you have stated is
5 the way that it is written here, the other sex.

6 BY MR. BLAKE:

7 Q. Do you disavow this article?

8 A. No, I do not.

9 Q. In fact, you agree that sex and gender
10 are actually totally different concepts, right?

11 MS. INGELHART: Objection, misstates
12 prior testimony.

13 BY THE WITNESS:

14 A. No, I do not.

15 BY MR. BLAKE:

16 Q. I'm reading from Confessions of a Gender
17 Defender again, Page 128. At the very top of the
18 page, and I'm happy to show it to you, "there is a
19 tendency in western societies to confuse sex with
20 gender. They are truly different concepts." Do
21 you recall writing that?

22 A. That's referring to sexual orientation
23 or sexual activity, not sex as our conversation
24 today, chromosomes and the categories of male and

1 female.

2 Q. Okay. So just placed in its proper
3 context, you agree with that statement?

4 A. The statement as it is written here?

5 Q. The statement as it's written in your
6 book.

7 A. Yes, which is why I said that
8 transsexualism was no longer a term that was in
9 common parlance because it conflated sex which for
10 lay people means sexual orientation, sexual
11 behavior with gender.

12 Q. Go back to Defendant's Exhibit 11 which
13 is your expert report. We're going to move on from
14 Page 5, you'll be happy to know. It's an
15 illuminating page clearly. We're going to skip
16 Page 6 and Page 7, and we're going to settle on
17 Page 8.

18 A. 8?

19 Q. Yes, Paragraph 31. And I believe this
20 is the paragraph that we talked about briefly at
21 the beginning of the deposition about the 2015
22 study related to suicide rates or risk among
23 transgender community, right?

24 A. Yes.

1 Q. And instead of spending a lot of time on
2 inquiry over who authored the study and things of
3 that nature, I think I understand that now, but I
4 do have some general questions about how the study
5 was conducted and its findings, so I would just
6 like to spend a few minutes on that.

7 You write on Page 9, and this is
8 just, you know, a part of the sentence, but it says
9 "demonstrating that in a hypothetical sampling of a
10 thousand transgender people." What do you mean by
11 hypothetical sampling?

12 A. If you were to take 1,000 people, which
13 of course we can't do, but hypothetically if we
14 could gather 1,000 subjects.

15 Q. In this case transgender people, right?

16 A. Correct. According to their Bauer, et
17 al, the study that they did, what they found in
18 their results was that completing a medical
19 transition related to a decrease in suicide
20 ideation and attempts, and having congruent
21 identity documents likewise conferred a
22 protective -- had a protective effect on
23 transgender people.

24 Q. You conclude or they conclude and you

1 report that of the -- out of the thousand
2 hypothetical transgender people who have permitted
3 a change in identity documents, 90 cases of
4 ideation could be prevented, right.

5 A. Yes, that's their conclusion.

6 Q. That's their conclusion.

7 Help me out. What's the difference
8 between ideation and actual suicide?

9 A. Well, actually there's three components
10 here. Ideation is the person who thinks about
11 suicide and contemplates committing suicide and
12 plans how they would execute a suicide.

13 A suicide attempt is someone who
14 actually hurts themselves with the attempt of
15 ending their life, and a completed suicide is
16 someone who is successful.

17 Q. Okay. I think I understand which
18 explains the second part where you say, this is
19 another hypothetical group, which is even more
20 difficult to locate, and these are the 1,000
21 hypothetical transgender people who have the
22 ideation, right, the ideation of suicide?

23 A. Yes.

24 Q. So you would need 90,000 hypothetical

1 transgender people to get a group that large. I
2 think that's right.

3 A. I would have to review their methods. I
4 only can say that this article is peer reviewed, so
5 apparently statistically and methodologically it
6 was rigorous enough.

7 Q. To pass that threshold?

8 A. Oh, yes, and to be in a journal with an
9 impact factor. So I would have to reread it to see
10 how they actually -- you know, look at their
11 statistical methodology.

12 Q. So out of -- I'm just trying to make
13 sure I understand. You got a hypothetical group of
14 a thousand transgender people, right?

15 A. We know that transgender people, the
16 majority or like almost 50 percent have attempted
17 suicide. 43 percent is what the Williams Institute
18 has documented have made attempts. So here with
19 this massive study that they have done, they've
20 shown that 230 of those --

21 Q. Attempts?

22 A. -- attempts could have been prevented.
23 So there's something protective is ultimately the
24 distillate of this research.

1 Q. So a quarter, roughly a quarter of the
2 people who -- quarter of the transgender people who
3 attempt suicide could be prevented with proper
4 documentation?

5 A. According to this study.

6 Q. According to the study?

7 A. And their findings. What we know is
8 that regardless of the numbers, we know and the
9 standard of care tells us that having congruent
10 identity documents attenuate gender dysphoria.

11 The attempted suicides are a result,
12 many of them or a quarter of them are likely the
13 result of gender dysphoria. Perhaps some of them
14 are related to some other mental illness.

15 Q. That's called like co-morbidity, right?

16 A. Co-occurring morbidity or co-morbidity.

17 Q. Where you have lots of different
18 psychological problems running sort of in parallel?

19 A. Correct.

20 Q. May or may not be related?

21 A. Correct.

22 Q. It's kind of hard to tell and frankly
23 probably immaterial, right? You want to treat the
24 person as opposed to --

1 A. Treat all.

2 Q. Right. Do you know what their actual
3 non-hypothetical sample size was?

4 A. No, I would have to review the article.

5 Q. It's in the report. I can get it in the
6 report if I was interested, right?

7 A. Okay.

8 Q. I mean, I just was asking if you knew
9 offhand.

10 A. Yes.

11 Q. I didn't have a chance to look at it
12 before.

13 Now, at this point -- Now, this
14 study was conducted in 2015?

15 A. 2015.

16 Q. So four years ago give or take. It's a
17 study out of Canada, right?

18 A. Correct.

19 Q. Do you know offhand whether the
20 sample -- the people they sampled were Canadian or
21 from the United States? Do you know?

22 A. I believe they were from Ontario, but I
23 would have to review the article.

24 Q. Do you know what Ontario's laws are

1 regarding changing your identity, changing the sex
2 marker, gender marker?

3 A. No, not offhand.

4 Q. You don't know if Canada just lets
5 people?

6 A. Some provinces I believe do because
7 there is a CPAP chapter, so at one point we
8 reviewed that, but I don't recall.

9 Q. Well, do you know what kind of identity
10 documents were involved in the study?

11 A. I don't recall.

12 Q. Do you recall if that was indicated in
13 the study?

14 A. I don't recall.

15 Q. So it could have been like whatever
16 their equivalent of a driver's license is in
17 Canada? It's probably called a driver's license.

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

20 BY MR. BLAKE:

21 Q. It could have been that, right?

22 A. I would have to review the article.

23 Q. Okay. Don't know if it was a birth
24 certificate though, right?

1 A. I don't know what documents they are
2 referring to.

3 Q. Do you know whether the study even
4 controlled for the type of identity document
5 involved?

6 A. I don't know the methodology of the
7 study without rereading it.

8 Q. Do you know whether the study controlled
9 for individuals who were born in a province that
10 allowed for these types of changes to the identity
11 documents to occur?

12 A. I don't recall.

13 Q. Do you know just as a general matter
14 whether transgender individuals born in a province
15 or even state like the United States have a higher
16 or lower rate of suicide if they are born in a
17 state or province that doesn't allow them to make
18 these changes to their identity documents?

19 A. I don't know of any documentation to
20 that effect. I know there's an article that
21 documents more suicide in states that have sex
22 segregated facilities.

23 Q. You mean like bathrooms and locker
24 rooms?

1 A. Uh-huh, and dormitories.

2 Q. So do you have the name of that? Is it
3 in your bibliography?

4 A. It might be in my bibliography.

5 Q. Go ahead and see if you can find it.

6 A. "Trans Adults Access to College
7 Bathrooms."

8 Q. What page are you on?

9 A. I'm on Page 4.

10 Q. Page 4 of Exhibit B to the --

11 A. That's the Seelman article, 2016.

12 Q. Page 4 to Exhibit B to Defendant's
13 Exhibit 11, the Seelman article, "Trans Adults
14 Access to College Bathrooms and Housing in
15 relationship to Suicidality." Is that the
16 article?

17 A. Yes.

18 Q. And your understanding of that article
19 is that in those states where segregated -- with
20 segregated access, rates of suicides are higher?

21 A. Yes.

22 Q. Okay. Do you know whether the 2015
23 Ontario study controlled for people who had a
24 diagnosis of gender dysphoria?

1 A. I don't know that.

2 Q. Do you know if the study controlled for
3 people in varying stages of transition?

4 A. I don't recall.

5 Q. Do you believe a diagnosis of gender
6 dysphoria should be required before a person is
7 able to change the sex marker on his or her birth
8 certificates?

9 MS. INGELHART: Objection, calls for a
10 legal conclusion. You can answer.

11 BY THE WITNESS:

12 A. Would you repeat the question?

13 BY MR. BLAKE:

14 Q. Yeah. Do you believe that a diagnosis
15 of gender dysphoria should be required before a
16 person is able to change the sex marker on his or
17 her birth certificate?

18 MS. INGELHART: Also objection to
19 incomplete hypothetical. You can answer.

20 BY THE WITNESS:

21 A. I don't believe that, no.

22 BY MR. BLAKE:

23 Q. Do you believe that a person needs to
24 undergo a certain amount of transition before

1 requesting a change to the sex marker on their
2 birth certificate?

3 MS. INGELHART: Same objection as to
4 legal conclusion and incomplete hypothetical. You
5 can answer.

6 BY THE WITNESS:

7 A. I'm not certain what you mean by a
8 certain amount of transition.

9 BY MR. BLAKE:

10 Q. Well, I mean, there are like stages of
11 transition, right? A person will come to you, for
12 example, and say, you know, I'm -- I feel my gender
13 is incongruous with my sex. They probably won't
14 say it like that. They probably never do. But,
15 right, I mean, that's the sort of --

16 A. There's a self disclosure.

17 Q. Some sort of self disclosure. And then
18 you would diagnose them oftentimes with gender
19 dysphoria but not all the times, right?

20 A. If I make a diagnosis.

21 Q. If you make a diagnosis. The next step
22 for that person if they choose is to start
23 undergoing a transition of some sort, right?

24 A. Not necessarily.

1 Q. Well, if they choose. They don't have
2 to. They can continue presenting themselves and
3 living as their sex assigned at birth if they
4 choose?

5 A. Correct.

6 Q. But in the case of someone who doesn't
7 want to do that, the next logical step for them is
8 to start making steps towards transition, right?

9 A. Some people might undergo a social
10 transition.

11 Q. Right. And so that would be sort of the
12 least friction, like easiest -- well, maybe not
13 easy, but, you know, first step that some people
14 choose to undertake?

15 A. Not necessarily. Some people might
16 undergo hormonal --

17 Q. That's another example of a step towards
18 transition that someone can take, right?

19 A. Someone could undergo a hormonal
20 intervention.

21 Q. Right.

22 A. Without transitioning socially.

23 Q. Correct. Someone could also change
24 their name, that would be another step someone

1 could take to be more male or female, right?

2 A. If they choose.

3 Q. If they choose, right. That's another
4 step in transition, right? And sort of, I suppose,
5 the most drastic step is for people to undergo a
6 medical procedure to actually have parts of their
7 anatomy changed to conform with their gender
8 identity, right?

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

11 BY MR. BLAKE:

12 Q. That's another step in the transition,
13 right?

14 A. I'm assuming you're talking about a
15 surgical intervention, not a medical intervention.

16 Q. Surgical, yes. So those are all steps
17 I think in a person's transition that they can
18 choose to take and they don't have to take them in
19 order?

20 A. They are all options for people.

21 Q. And you can do them in any order you
22 want?

23 A. No. You can't have certain
24 interventions without first having preliminary

1 interventions.

2 Q. Yeah, I understand that. That's the
3 law. I don't know if it's in most states or all
4 states but you have to --

5 A. It's the standard of care.

6 Q. You have to live or transition certain
7 parts of your life before you do some of the like
8 more permanent surgical interventions, right?

9 A. There are certain criteria that have to
10 be met before people can have medical or surgical
11 interventions.

12 Q. Understood.

13 So setting those aside, there are
14 some preliminary steps in transition that a person
15 can undergo, right?

16 A. Prior to medical interventions or
17 surgical interventions.

18 Q. Okay. So that's what I talk about when
19 I say certain transition. That's what I mean, the
20 steps in a transition.

21 So do you believe a person needs to
22 undergo a certain number of those steps in
23 transition before they are able to request a change
24 on the sex marker of their birth certificate?

1 MS. INGELHART: Objection, calls for a
2 legal conclusion. You can answer.

3 BY THE WITNESS:

4 A. My answer is that it's not what I
5 believe. My experience is that when people
6 socially transition and present in a gender other
7 than the one in which they were assigned, then they
8 will request to have congruent identity so that
9 their daily interactions are safe and private and
10 allow them to live safely and comfortably in their
11 affirmed gender.

12 BY MR. BLAKE:

13 Q. Your experience is people socially
14 transition prior to requesting these changes to
15 their identification documents?

16 A. The majority of people would do so.

17 Q. But you don't believe that that's a
18 requirement, right?

19 MS. INGELHART: Objection, calls for a
20 legal conclusion. You can answer.

21 BY THE WITNESS:

22 A. I don't know that there's a requirement.
23 I think that different states have different
24 requirements, and I'm not privy to all of that. My

1 experience is with the people who actually do
2 undergo transitions and then try to have documents
3 that reflect their lived experience.

4 BY MR. BLAKE:

5 Q. And it's not your opinion or belief that
6 someone should have to undergo hormone therapy
7 before requesting a change to their identity
8 documents, right?

9 MS. INGELHART: Same objection, legal
10 conclusion. You can answer.

11 BY THE WITNESS:

12 A. I don't believe people should have to
13 undergo hormonal therapy prior to having congruent
14 documents.

15 BY MR. BLAKE:

16 Q. You don't believe someone should have to
17 undergo some amount of surgical intervention before
18 having congruent identity documents, right?

19 A. Correct.

20 MS. INGELHART: Same objection to legal
21 conclusion and incomplete hypothetical.

22 THE WITNESS: I'm sorry I spoke before
23 you entered your objection.

24 MS. INGELHART: It's okay.

1 BY MR. BLAKE:

2 Q. Would you agree that no amount of gender
3 transition can change a person's chromosomes,
4 right?

5 MS. INGELHART: Objection, calls for
6 speculation and incomplete hypothetical. You can
7 answer.

8 BY THE WITNESS:

9 A. I don't think that chromosomes change
10 with a gender transition.

11 BY MR. BLAKE:

12 Q. And no amount of gender transition can
13 change the sex of the individual as identified by
14 the medical provider at the time of birth, right?

15 MS. INGELHART: Objection, calls for --
16 well, objection to terms and legal conclusion and
17 speculation. You can answer. Incomplete
18 hypothetical.

19 BY THE WITNESS:

20 A. I don't understand the question.

21 BY MR. BLAKE:

22 Q. Sure. There's a sex identified at the
23 time of birth?

24 A. Correct.

1 Q. Based on what you described as a cursory
2 inspection of the external genitalia, right?

3 A. Yes.

4 Q. No amount of gender transition can
5 change that?

6 A. No, I believe birth certificates are
7 changed routinely in 48 states.

8 Q. Right, but that doesn't change the sex
9 that was observed and reported by the medical
10 provider at the time of birth?

11 A. Correct, it doesn't change --

12 MS. INGELHART: Objection.

13 BY THE WITNESS:

14 A. -- the primary sex characteristic of the
15 infant.

16 BY MR. BLAKE:

17 Q. You said you reviewed the complaint
18 prior to drafting your expert opinion, right?

19 A. Yes.

20 Q. Do you know whether any of the
21 plaintiffs feared physical harm when they disclosed
22 their birth certificate based on what you reviewed
23 in the complaint?

24 A. Yes.

1 Q. And do you believe that they feared
2 physical harm when they disclosed their birth
3 certificates?

4 A. I believe that knowing that their birth
5 certificates were inconsistent with their gender
6 presentation, they were always fearful of having to
7 expose that.

8 Q. But did they fear physical harm?

9 A. Oh, I don't know if they feared physical
10 harm. I'm going to have to ask to take a break and
11 go to the restroom.

12 Q. Okay.

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

15 MR. BLAKE: Back on the record.

16 BY MR. BLAKE:

17 Q. With regards to any of the plaintiffs in
18 this case, do you believe that the medical provider
19 made an error when the sex was recorded on his or
20 her birth certificates?

21 A. No.

22 Q. Do you believe that medical providers in
23 general should be required to conduct any
24 additional medical procedures to determine a

1 child's sex at birth?

2 A. No.

3 (Document marked as Defendant's
4 Exhibit No. 18.)

5 Q. I just handed you what has been marked
6 as Defendant's Exhibit 18 which is a copy of the
7 expert report submitted by Dr. Van Meter. Have you
8 seen this document before?

9 A. Yes.

10 Q. Okay. In fact, you said you reviewed
11 these documents after you submitted your report,
12 right?

13 A. Yes.

14 Q. I'm going to ask you to turn to Page 3
15 in Paragraph 14. "From the moment of conception, a
16 fetus is determined to be either a male XY, female
17 XX or in rare cases to have a combination of sex
18 determining chromosomes, many of which are not
19 compatible with life and some of which are the
20 cause of identifiable clinical syndromes." Do you
21 see that sentence?

22 A. I do.

23 Q. Do you agree with that?

24 A. Yes.

1 Q. "The presence of a Y chromosome in the
2 developing fetus directs the developing gonadal
3 tissue to develop a testicle." Do you agree with
4 that conclusion?

5 A. Yes.

6 Q. "The absence of a functional Y
7 chromosome allows the gonadal tissue to develop as
8 an ovary." Do you agree with that?

9 A. Yes.

10 Q. "Under the influence of the mother's
11 placental hormones, the testicle will produce
12 testosterone which directs the genital tissue to
13 develop a penis and a scrotum." Do you agree with
14 that conclusion?

15 A. More or less.

16 Q. "Simultaneously the testicle produces
17 anti-mullerian hormone, AMH, which regresses
18 development of the tissue that would otherwise
19 develop into the uterus, fallopian tubes and upper
20 third of the vagina." Do you agree with that
21 conclusion?

22 A. Yes.

23 Q. "There is no process or procedure that
24 will alter a person's chromosomes." You agree with

1 that, right?

2 A. Yes.

3 Q. Paragraph 15. Let me see if I can short
4 circuit of this. If you would please read
5 Paragraph 15 and let me know if you agree with the
6 conclusions in Paragraph 15. You can read it
7 silently if you prefer.

8 A. I agree with Paragraph 15.

9 Q. All right. Same question for
10 Paragraph 16, is there any conclusion in
11 Paragraph 16 with which you disagree?

12 A. I believe I disagree with No. 16.

13 Q. Which part of Paragraph 16 do you
14 disagree with?

15 A. The incidents of disorders of sexual
16 differentiation.

17 Q. Okay. "The incidents of such
18 circumstances occurs in 1 out of 4,500 to 1 in
19 5,500 births," is that the part you disagree with?

20 A. Yes. I'm not certain that I agree with
21 those numbers, and I would have to look at my own
22 sources, which I don't have with me.

23 Q. You think the rate of DSD might be
24 higher?

1 A. I do.

2 Q. Okay. And by DSD we mean disorders of
3 sexual differentiation?

4 A. Correct.

5 Q. But other than that, you agree with the
6 rest of the conclusions in Paragraph 16?

7 A. Yes.

8 Q. Paragraph 17, do you disagree with any
9 conclusions in Paragraph 17?

10 A. I disagree with 17.

11 Q. What aspect of Paragraph 17 do you
12 disagree with?

13 A. I don't think sex is necessarily binary.
14 I think that chromosomes are one component of sex,
15 and I don't think that it's the Intersex Society of
16 North America that puts out that consensus
17 statement, but I am not certain about that.

18 Q. Sex assigned at birth is, in the absence
19 of a disorder, male or female, right?

20 A. Yes. It is designated clerically, yes.

21 Q. You agree that that designation itself
22 would be binary in the normal circumstance, right?

23 A. Yes.

24 Q. You said you also agreed with the 2016

1 consensus statement of the Intersex Society of
2 North America?

3 A. No, I don't believe that is the
4 Intersex Society of North America that made that
5 statement, but I'm not certain about that. In
6 other words, I'm not certain that I agree and will
7 not state that I agree with Paragraph No. 17 in its
8 entirety.

9 Q. Right. But you said disagreed with sex
10 is binary male or female, that aspect of it,
11 right?

12 A. I disagree with that.

13 Q. Okay. But you agree that the sex as
14 identified at birth is in the normal circumstances
15 binary, correct?

16 A. It's documented as being binary.

17 Q. You disagree with sex being determined
18 by chromosomal complement?

19 A. Alone.

20 Q. And your basis for disagreement are
21 those five components that we talked with earlier?

22 A. Correct.

23 Q. Okay. Then you disagree with the way
24 that Dr. Van Meter has identified this 2006

1 consensus statement?

2 A. I would need to myself see documentation
3 before I would agree with that statement. I don't
4 know.

5 Q. You just don't know what the statement
6 is that he's referring to?

7 A. I don't know what the statement is, but
8 I think the Intersex Society of North America, if
9 it's what I think it is, then I am not in agreement
10 with that, that they are the source of that
11 statement.

12 Q. Okay. It's not that you -- you don't
13 take issue with -- I guess I was confused. Do you
14 think that the Intersex Society of North America
15 exists?

16 A. I'm not certain that that statement is
17 accurate, that's my opinion, as it's written.

18 Q. In what way is it inaccurate?

19 A. I'm not certain that it's accurate the
20 way it's written.

21 Q. Okay. Is there an organization called
22 the Intersex Society of North America?

23 A. There is an Intersex Society, and it is
24 made up of consumers, and I'm not certain that this

1 is their consensus statement. I don't know. I
2 would have to check that.

3 Q. Okay. Go to Paragraph 19. Read that
4 and let me know if you agree with the conclusions
5 in that paragraph.

6 A. I do not.

7 Q. Which conclusions do you disagree with?

8 A. In the first sentence DSD patients are
9 not transgender. Some, in fact, are.

10 Q. Some, but not all, right?

11 A. This conclusively says DSD patients are
12 not transgender.

13 Q. Okay. Is there anything --

14 A. I do not agree with that statement.

15 Q. Is there anything about a DSD patient
16 that makes them more or less likely to be
17 transgender --

18 A. Yes.

19 Q. -- in your opinion?

20 A. Yes, they are more likely to be
21 transgender than the normal population because they
22 have some anomalies.

23 Q. One of those components of sex is
24 somewhat ambiguous?

1 A. Correct.

2 Q. Do you disagree with anything else in
3 Paragraph 19?

4 A. I don't know. I'm not an expert on DSD,
5 so I don't want to overstate my agreement or
6 disagreement with diagnostic subgroups of the
7 chromosomal anomalies.

8 Q. Okay. So that the conclusions in 19 are
9 outside your area of expertise and you are not
10 offering an opinion one way or the other on those
11 conclusions?

12 A. I'm offering an opinion that the
13 statement DSD patients are not transgender. Some
14 DSD patients are transgender and do make gender
15 transitions.

16 Q. Okay.

17 A. I disagree with the statement that says
18 people who identify as feeling like the opposite
19 sex or somewhere in between do not comprise a third
20 sex. Transgender people don't feel like the
21 opposite section. They have a gender identity that
22 is incongruous and it's not based upon a feeling.
23 They meet certain criteria as outlined in the DSM-5
24 as we have already discussed.

1 Q. Paragraph 21, do you agree with the
2 conclusions in that paragraph?

3 A. I don't know that gender is a
4 psychological concept, I've never heard that
5 before, or a sociological term. I don't agree that
6 it possesses a linguistic, solely a linguistic
7 meaning prior to the 1950s. I've never seen any
8 documentation of that.

9 I don't know what sexologists
10 manipulated the term to conceptual cross dressing
11 and transsexualism in their psychological practice.
12 I disagree with that. That doesn't comport with
13 my understanding of this field that I specialize
14 in.

15 Q. What are the origins of the gender and
16 gender diversity and transgender specialization of
17 your practice?

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

20 BY THE WITNESS:

21 A. I'm sorry, can you be more specific?

22 BY MR. BLAKE:

23 Q. So, I mean, you identified four areas
24 which you have expertise in and within the field of

1 psychology, right?

2 A. Correct.

3 Q. And one of those relates to the
4 transgender issues we've been talking about today,
5 right?

6 A. Yes.

7 Q. Historically, right, what are sort of
8 the origins of that branch your practice?

9 A. Well, as I mentioned before, I started
10 seeing individuals who were patients in the late
11 '70s. My aunt was Harry Benjamin's disciple.
12 Harry Benjamin was the person who first introduced
13 the term transsexualism, as you may know, and wrote
14 the book The Transsexual Phenomenon. Christine
15 Jorgensen was his seventh patient.

16 Q. That was in the 1950s?

17 A. 1950s, correct. She was his patient
18 in I think -- well, she was his seventh patient.
19 She came back from Denmark and came to the United
20 States. In Denmark she had a partial sex change
21 and she needed to complete her surgery in the
22 United States.

23 In BC, Ovid, the BC poet, talked
24 about the pregnant -- the yearn of a pregnant mare

1 to change one's sex which is Premarin, which is
2 still in use today. It's a female estrogen. So
3 there have been transgender people since the
4 beginning of history and they exist in all
5 cultures.

6 So this idea that sexologists
7 manipulated gender to conceptualize cross dressing
8 and transsexualism in their psychological practice,
9 I don't know what sexologists your expert is
10 referring to. I don't know whose psychological
11 practice or what psychological practice this refers
12 to. So Paragraph 21 I think is rather meaningless
13 to me.

14 Q. You may disagree with the way he
15 characterized things in Paragraph 21, but you would
16 agree that at least that modern transgender studies
17 has its origins with Harry Benjamin in the 1950s;
18 is there accurate?

19 A. Harry Benjamin coined the phrase
20 transsexual, but Magnus Hirschfield in Germany in
21 the '30s, I believe, described individuals who had
22 a need to present in a gender that was other than
23 that which they were assigned at birth in what you
24 call detransvestism, so the phenomenon has existed

1 for years, but it was only really with Christine
2 Jorgensen that it became known to the public in the
3 '50s.

4 Q. In the '50s?

5 A. Yes.

6 Q. Okay. Paragraph 22, do you agree with
7 the conclusions in that paragraph?

8 A. I don't know when John Money termed
9 the --

10 Q. Termed the gender identity phrase?
11 Setting aside the chronology, you know, as far as
12 the content of Paragraph 22.

13 A. I would agree that most individuals have
14 a gender identity that aligns with their assigned
15 sex. I would not say that gender incongruity is a
16 psychological condition.

17 Q. Move down to Paragraph 23.

18 A. Yes.

19 Q. You disagree with gender incongruity as
20 a psychological condition?

21 A. Yes, I wouldn't describe it primarily as
22 a psychological condition.

23 Q. Would you agree with the conclusion in
24 Paragraph 24?

1 A. I don't agree with that.

2 Q. You disagree with the --

3 A. With the way that's phrased, yes.

4 Q. With gender incongruity?

5 A. I'm disagreeing with this idea that he
6 or she will often express the belief that he or she
7 is the opposite sex.

8 Q. I got it. You rejected Paragraph 23. I
9 am on to Paragraph 24. Do you disagree with the
10 conclusions?

11 A. Paragraph 24 is wrong.

12 Q. In what way?

13 A. In the way that in 2016 or the 2016
14 epidemiologists at Emory University concluded that
15 a gender incongruity occurs in between .2 and
16 .7 percent of the population.

17 Q. So you think the numbers are higher?

18 A. Oh, the numbers are definitely higher.

19 Q. Paragraph 25, do you agree with the
20 conclusions in that paragraph?

21 A. Gender dysphoria is a medical condition,
22 and it does cause emotional distress.

23 Q. So more or less other than maybe the use
24 of the term gender incongruity?

1 A. No, gender incongruity is probably --

2 Q. Accurate?

3 A. Well, the World Health Organization in
4 the next international classification in ICD will
5 probably use the term gender incongruity. We
6 actually met with members of the World Health
7 Organization and decided that that was an
8 appropriate term.

9 Q. So 25, there's nothing offensive about
10 25?

11 A. Well, I wouldn't call gender dysphoria a
12 diagnostic term.

13 Q. What kind of term would you call it?

14 A. I would call it a medical condition.

15 Q. Okay. Medical condition.

16 A. Yes.

17 Q. Otherwise you're perfectly fine with
18 that statement?

19 MS. INGELHART: Objection,
20 mischaracterizes prior statement.

21 BY THE WITNESS:

22 A. I wouldn't say I'm perfectly fine. I
23 would say that it's a medical condition that is
24 diagnosed when a person experiences significant

1 clinical distress that impairs their ability to
2 function in a particular area, which is the DSM-5
3 definition.

4 BY MR. BLAKE:

5 Q. You would adopt the DSM-5 definition for
6 gender dysphoria?

7 A. Yes.

8 Q. Paragraph 26, do you agree with the
9 conclusions in that paragraph?

10 A. I agree with the first sentence that
11 there's no observable physical way to test for
12 gender dysphoria in the womb or at the time of
13 birth. I agree with that statement.

14 Q. Do you agree with the second sentence
15 too?

16 A. Yes.

17 Q. And I assume you agree with the last
18 sentence as well?

19 A. Gender nonconforming has been reported
20 in patients younger than four years of age.

21 Q. Even younger than four?

22 A. Uh-huh.

23 Q. And Paragraph 27, do you agree with the
24 conclusions in paragraph?

1 A. Chromosomes cannot be changed by a
2 medical procedure, I agree with that.

3 Q. Paragraph 29, do you agree with that
4 statement?

5 A. I agree that the birth certificates
6 record an individual's primary sex characteristics
7 at the moment of birth.

8 Q. And Paragraph 30, you agree with, right?

9 A. Yes.

10 Q. None of the plaintiffs have had
11 karyotyping done, so I assume if I asked you
12 whether or not you would agree with Dr. Van Meter's
13 opinion regarding what their chromosomes are, you
14 would say you don't have any information one way or
15 the other on that; is that accurate?

16 A. I would say not only do I not have that
17 information, I would say that he doesn't have that
18 information either.

19 Q. Would you agree though that most likely
20 their karyotype conforms with their sex assigned at
21 birth?

22 MS. INGELHART: Objection.

23

24 BY THE WITNESS:

1 A. I can't make that statement. I would
2 say in most cases, people's chromosomes do, and
3 that's true even of people who have gender
4 dysphoria; however, there is a higher incidents of
5 chromosomal anomalies in people who are gender
6 dysphoric, so for any given gender dysphoric
7 person, I can't state what their chromosomes are or
8 are not.

9 Q. It might be less likely than you or me
10 or more likely than you or me that they have some
11 sort of chromosomal abnormality, but still more
12 likely than not that they have the normal
13 karyotype; is that accurate?

14 A. That seems like a fair statement to
15 make.

16 MR. BLAKE: I have no further questions.

17 MS. INGELHART: Thank you. We'd like to
18 take a quick break.

19 MR. BLAKE: You just had a 30 minute
20 break. How long is it going to be? Off the
21 record.

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

24 MS. INGELHART: Back on the record.

1 Thank you. Plaintiff's counsel has just a few
2 questions for direct. I will instruct the witness
3 to remember that the court reporter is still to
4 your left so if you can project out so she can best
5 record.

6 E X A M I N A T I O N

7 BY MS. INGELHART:

8 Q. First I'm going to refer back to
9 Defendant's Exhibit 18 which is Dr. Van Meter's
10 initial expert report. Can we look to Page 5,
11 Paragraph 27?

12 Previously you testified that you
13 agreed with the first three sentences in this
14 paragraph.

15 A. I'm sorry, what paragraph?

16 Q. I will refer back now that opposing
17 counsel has reached the same page. Apologies.

18 We're looking at Paragraph 27.
19 Previously you testified that you concurred with
20 the first three sentences of this paragraph.
21 That's accurate, correct?

22 MR. BLAKE: Objection, misstates.

23 MS. INGELHART: I'll retract it.

24 BY MS. INGELHART:

1 Q. Do you agree that there are no
2 procedures, medical or otherwise, by which an
3 individual can change chromosomes that determine
4 sex?

5 A. I agree. Chromosomes cannot be changed.

6 Q. Do you agree that hormone therapy,
7 surgical modifications can't change chromosomes one
8 is born with?

9 A. I agree with that statement.

10 Q. Do you agree that sex is innate?

11 A. I don't agree with that. I don't know
12 what that refers to, that sex. I don't know
13 what -- how he's conceptualizing sex.

14 Q. Thank you.

15 Do you agree that there's no
16 credible science proving that gender incongruity is
17 innate?

18 A. I do not agree with that.

19 Q. Do you agree with this last sentence
20 here then in Paragraph 27?

21 A. I do not.

22 Q. Thank you.

23 Referring down on the same page to
24 Paragraph 30, I would like to revisit prior

1 testimony. Do you agree that gender identity is
2 not observable or detectable at the time of birth?

3 A. I agree with that.

4 Q. Do you agree that gender identity is not
5 recorded on Ohio birth certificates?

6 A. Yes.

7 Q. What is recorded on Ohio birth
8 certificates?

9 A. The infant's primary sex characteristic.
10 Penis or vagina is what is recorded as male or
11 female at the time of birth.

12 Q. Thank you.

13 In your experience, would it
14 support a binary transgender person's social
15 transition to have a binary gender or sex marker
16 that matches their gender identity on their birth
17 certificate?

18 MR. BLAKE: Objection, vague.

19 BY THE WITNESS:

20 A. Yes.

21 BY MS. INGELHART:

22 Q. In your experience, what kind of
23 requirements for accessing accurate identity
24 documents, ones that match a transgender person's

1 gender identity, have been correlated with the most
2 affirming social transitions?

3 A. Those that are least burdensome.

4 Q. Thank you.

5 Some terms of art were used today
6 interchangeably with antiquated terms. Generally
7 why has medical society evolved from using terms
8 like natal sex to sex assigned at birth or
9 transsexual to gender dysphoria?

10 A. Natal implies something that is
11 permanent. Sex assigned at birth is temporal.
12 Transsexualism conflates sex, be it sexual
13 orientation, sexual behaviors or sexual activity
14 with gender, and lay people in particular confuse
15 sexuality with gender leading to some serious
16 negative connotations for people who are
17 transgender.

18 Q. Is the term sex assigned at birth more
19 accurate than natal sex?

20 A. Yes.

21 MR. BLAKE: Objection.

22 BY MS. INGELHART:

23 Q. Is the term gender dysphoria a more
24 accurate term than transsexual?

1 MR. BLAKE: Objection.

2 BY THE WITNESS:

3 A. Yes.

4 BY MS. INGELHART:

5 Q. Have you ever had a client or patient
6 face negative outcomes as a result of experiences
7 or instances related to inaccurate identity
8 documents, identity documents that did not
9 correlate or match their gender identity?

10 A. Yes.

11 Q. Can you please provide an example?

12 A. I had a patient who committed suicide,
13 shot herself in the head after producing a document
14 that didn't align with her gender presentation.
15 She went home and killed herself. That was one
16 unfortunate and very dramatic occasion.

17 On another occasion a woman who was
18 a trans woman who had transitioned as an adolescent
19 and was married, although she was an extremely
20 authentic and actually a very beautiful woman,
21 someone revealed a document that had a male birth
22 name on it, and she and her husband were so
23 victimized and harassed by co-workers, they had
24 their brake lines cut, death threats.

1 The workers took out a petition that
2 she couldn't use the female restroom. They smeared
3 feces on her desk. She and her husband
4 developed -- her husband was taunted for being gay
5 because he was married to someone who was really a
6 man and people would bring sex toys to his office.

7 They are both completely disabled.
8 They are unable to leave their homes. They have
9 panic attacks. The man pulled all his hair out of
10 his head and lost 50 pounds in a month, and they
11 are both on permanent, extended disability and are
12 physically and psychologically damaged, extremely
13 damaged.

14 Q. Just to clarify, that classification as
15 disabled is a result of the harassment; is that
16 correct?

17 A. Yes. They have what is known as complex
18 PTSD. Complex PTSD is unlike random PTSD which is
19 acts of God, like a tornado or a car accident.
20 Complex PTSD is caused by human beings. It's
21 intentional and it occurs intermittently and
22 repeatedly so people don't have time to regain
23 their equilibrium in between these assaults, and so
24 it's more intractable and more severe than random

1 acts of God which aren't personal.

2 MS. INGELHART: Thank you. I don't have
3 any further questions.

4 MR. BLAKE: I don't have any followup
5 questions.

6 MS. INGELHART: We would like to have the
7 opportunity to sign later.

8 (Witness excused.)

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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.

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IN WITNESS WHEREOF, I do hereunto set my
hand this October 7, 2019.



MARI BETH KAWULIA, CSR
C.S.R. No. 84-2873

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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 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.

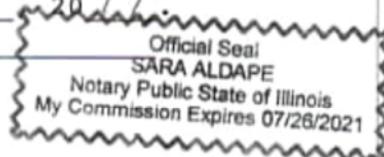
10.25.19 Randi Ettner, Ph.D.
Date Randi Ettner, Ph.D.

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



7/26/2021
Commission Expiration Date

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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

[& - 5]

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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.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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