

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

ASHLEY DIAMOND,

Plaintiff,

v.

TIMOTHY WARD, et al.,

Defendants.

CASE NO. 5:20-CV-00453-MTT

DECLARATION OF DR. RANDI ETTNER

1. My name is Dr. Randi C. Ettner. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria.
2. I have been retained by counsel for Ashley Diamond (“Ms. Diamond”) to provide the Court with scientific information about gender dysphoria and the standard of care for treatment, and to provide my expert medical opinion regarding what would constitute “adequate medical care” to treat Ms. Diamond’s gender dysphoria. Except where noted, I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.
3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I am also a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder. I received my doctorate in psychology (with honors) from Northwestern University in 1979.
4. I am currently on the medical staff at Weiss Memorial Hospital Center for Gender Confirmation Surgery in Chicago, Illinois but began working with individuals with gender dysphoria nearly forty years ago, as an intern at Cook County Hospital.

5. I have evaluated, diagnosed, and treated more than 3,000 individuals with gender dysphoria and mental health issues related to gender dysphoria from 1985 to present.
6. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery* (Ettner, Monstrey, & Eyler; Routledge, 2007) and the 2d edition (co-editors Monstrey & Coleman; Routledge, June 2016). I also have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.
7. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgender Health*. I am the immediate past Secretary of the World Professional Association of Transgender Health (WPATH) and served as a member of the Board of Directors for twelve years, and am an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version) (“Standards of Care”), published in 2011. WPATH is an international association of 2,500 medical and mental health professionals specializing in the treatment of gender diverse people. I chair the WPATH committee for institutionalized persons and provide training to medical professionals on healthcare for transgender inmates.
8. The Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.
9. I have lectured throughout North America, Europe, South America and Asia on topics related to gender dysphoria, and frequently give grand rounds presentations on gender dysphoria at medical hospitals. I am the honoree of the externally-funded *Randi and Fred Ettner Fellowship in Transgender Health* at the University of Minnesota. I have been an invited guest at the

National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH in gender dysphoria.

10. I have been retained as an expert in multiple federal court proceedings involving the treatment of gender dysphoria in prison settings, and have been repeatedly qualified as an expert.
11. My clinical consulting fee is \$400 per hour.
12. A true and correct copy of my *Curriculum Vitae* is attached hereto as **Appendix A**.

I. MATERIALS CONSIDERED

13. In preparing this declaration, I relied on clinical interviews I conducted with Ashley Diamond on March 12, 2021 and on January 22, 2015, Ms. Diamond's mental health and medical records with the Georgia Department of Corrections and the complaints in her cases, the results of psychodiagnostic exams I administered to Ms. Diamond, my extensive professional experience, and the body of medical literature, including my own, concerning gender dysphoria.
14. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive experience and review of the literature related to gender dysphoria over the past several decades. Attached as **Appendix B** is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration.

II. BACKGROUND ON GENDER IDENTITY AND GENDER DYSPHORIA

15. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectable through karyotyping); gonads and internal reproductive organs (detectable by ultrasound and physical pelvic exam); external genitalia (which are visible at birth); sexual differentiation in brain development and structure (detectable by functional magnetic resonance imaging studies and autopsy); and gender identity. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a gender, such as male or female. Gender identity is firmly established early in life (Halim & Ruble, 2010; Golombok et al., 2008; Ruble et al., 2007; Steensma et al., 2011; Steensma et al., 2013).
16. At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. This classification becomes the person's birth-assigned sex. Typically, persons born with the physical characteristics of males identify as male, and those with the physical characteristics of females identify as female. However, for transgender individuals, this is not the case. For transgender individuals, one's body and gender identity do not match, giving rise to a sense of being "wrongly embodied." The medical diagnosis for that experience of incongruence and accompanying distress is gender dysphoria.
17. Gender dysphoria (previous nomenclature was gender identity disorder) is a serious medical condition that is codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition ("DSM-V"), and the World Health Organization's International Classification of Diseases, Tenth Edition (ICD-10).
18. Individuals with gender dysphoria, who are frequently referred to as "transgender," experience incongruence between their gender identity and birth-assigned sex, along with clinically

significant distress or impairment of functioning. The suffering that arises from gender dysphoria has often been described as “being trapped in the wrong body.”

19. “Dysphoria” is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition when it is unmanaged.
20. The DSM-V sets out the diagnostic criteria for Gender Dysphoria in Adolescents and Adults, including clinically significant distress or impairment in social, occupational or other important areas of functioning.
21. Owing to sophisticated new technologies, such as functional magnetic resonance imaging and genetic analysis instruments (Ettner, 2007), an assemblage of research led to scientific consensus that gender dysphoria has a biological, physiological etiology (see eg. Bentz et al., 2008; Guillamon, Junque, & Gomez-Gil, 2016; Hines, 2011; Rametti, 2011; Zubiaurre-Elorza et al., 2014). It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.*, Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment. A Diffusion Tensor Imaging Study*, 45 J. Psychiatric Res. 199-204 (2010); Giuseppina Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study*, 45 J. Psychiatric Res. 949-54 (2011); Eileen Luders et al., *Gender effects on cortical thickness and the influence of scaling*, 2 J. Behav. & Brain Sci. 357, 360 (2012); FPM Kruijver, et al., *Male-to-female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034-2041 (2000). Interestingly, differences in transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to

attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self (Longo & Haggard, 2010).

22. It is now believed that gender dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

During the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Ai-Min Bao & Dick F. Swaab, *Sexual Differentiation of the Human Brain: Relation to Gender Identity, Sexual Orientation and Neuro-psychiatric Disorders*, 32 *Frontiers in Neurology* 214-216 (2011). In addition, Alicia Garcia-Falgueras & Dick F. Swaab find that:

The fetal brain develops during the intrauterine period in the male direction through a direct action of testosterone on the developing nerve cells, or in the female direction through the absence of this hormone surge. In this way, our gender identity (the conviction of belonging to the male or female gender) and sexual orientation are programmed or organized into our brain structures when we are still in the womb. However, since sexual differentiation of the genitals takes place in the first two months of a pregnancy and sexual differentiation of the brain starts in the second half of the pregnancy, these two processes can be influenced independently, which may result in extreme cases in transsexuality. This also means that in the event of ambiguous sex at birth, the degree of masculinization of the genitals may not reflect the degree of masculinization of the brain. There is no indication that social environment after birth has an effect on gender identity or sexual orientation.

Alicia Garcia-Falgueras & Dick F. Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 *Pediatric Neuroendocrinology* 22-25(2010). Similarly, Lauren Hare et al. finds that:

a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Lauren Hare, et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 *Biological Psychiatry* 93, 93, 96 (2009). Because the condition is biologically based, efforts to change a person's gender identity are futile, cause psychological harm, and are unethical.

23. A person diagnosed with gender dysphoria experiences clinically significant emotional distress, meaning the distress resulting from gender incongruity interferes with activities of daily living or important areas of functioning. Without adequate treatment, individuals with gender dysphoria experience anxiety, depression, suicidality and other attendant mental health issues. (See, e.g., Fraser, 2009; Schaefer & Wheeler, 2004; Ettner, 1999; Brown, 2000, DSM-V, 2013, Haas et al., 2014).
24. Individuals without access to appropriate care, particularly those who are imprisoned, are often so desperate for relief that they resort to life-threatening attempts at auto-castration, the removal of one's testicles, in the hopes of eliminating the major source of testosterone that kindles the dysphoria. (Brown, 2010; Brown & McDuffie, 2009).
25. Gender dysphoria intensifies with age. Individuals commonly experience an intensification of symptoms at midlife. (Ettner & Wylie, 2013; Ettner, 2013).

III. TREATMENT OF GENDER DYSPHORIA

26. Gender dysphoria ameliorates through medical treatment. The medically accepted standards for the treatment of gender dysphoria are set forth in the Standards of Care, first published in 1979. The Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world. The American Medical Association, The Endocrine Society, The American Psychological Association, and The American Psychiatric Association all support treatment in accordance with the WPATH

standards. (See American Medical Association (2008) Resolution 122n (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing “the efficacy, benefit and medical necessity of gender transition treatments”)).

27. Like protocols for the treatment of diabetes or other medical disorders, the Standards of Care apply to the treatment of gender dysphoria in incarcerated and non-incarcerated settings, and have been recognized by the National Commission on Correctional Health Care (“NCCHC”) as the clinically accepted standards for the care of inmates with gender dysphoria. (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (October 18, 2009), <http://www.ncchc.org/transgender-health-care-in-correctional-settings>).

Hormone Therapy

28. The Standards of Care establish that for many individuals with gender dysphoria, hormone therapy is effective, essential, and medically necessary treatment. (Standards of Care, Section VIII.)
29. The Endocrine Society Guidelines are an evidence-based guideline for the hormonal treatment of transgender persons that were formulated using the Grading of Recommendations, Assessment, Development, and Evaluation (“GRADE”) system, and establish protocols for primary care physicians, endocrinologists, and other medical providers who administer cross-sex hormones to transgender patients.
30. The objective of hormone administration, as described by The Endocrine Society Guidelines, is to maintain “cross-sex hormone levels ... in the normal physiological range for the desired gender.” (The Endocrine Society Guidelines 2009). Accordingly, when transgender patients

receive therapeutic hormone therapy regimens, their “serum testosterone levels should be in the female range.” (The Endocrine Society Guidelines 2009).

31. For transgender women, The Endocrine Society Guidelines recommend an estrogen derivative—estradiol—to be delivered within the following protocol. If orally administered, 2-6 milligrams daily, (mg/d) and spironolactone, if orally, 100-300 mg/d. If parenteral estrogen, 5-30 mg intramuscularly injected (IM) every 2 weeks or 2-10 mg/ IM every week. The optimal dose of estrogen will depend on the individual patient, however. The dose should maintain the desired sex characteristics, relieve gender dysphoria, and prevent osteoporosis and mood disorders. In some cases, it may be necessary to increase the dose, but not exceeding a peak level of 400 picograms per milliliters (pg/ml.).
32. The treatment protocols recommended in The Endocrine Society Guidelines represent the medically accepted regimen for hormonal therapy and are reiterated in a number of medical publications. *See, e.g., Primary Care Protocol for Transgender Patient Care*, published by the University of California San Francisco Department of Family and Community Medicine (available at <http://transhealth.ucsf.edu/trans?page=protocol-hormones>); *the Practical Guidelines for Transgender Hormone Treatment*, published by the Boston University School of Medicine, Endocrinology, Diabetes & Nutrition (available at <http://www.bumc.bu.edu/endo/clinics/transgender-medicine/guidelines/>).
33. In order to facilitate the delivery of care to this underserved population, The Endocrine Society Guidelines and similar protocols are readily available to medical providers and widely disseminated.

Gender Affirmation

34. The Standards of Care also inform clinical guidance as to the importance of the social signifiers of gender expression in treatment. Clothing and grooming that affirms one's gender and the use of pronouns consistent with an individual's gender identity are an important component of treatment protocols. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007).
35. A key component of medical treatment for gender dysphoric individuals is to live, function in society and be regarded by others consistent with their gender identity. If any aspect of this gender affirmation regime is significantly impeded, it will undermine an individual's psychological health.
36. While it is obvious that the gender dysphoric individual suffers at the incongruity of appearance and gender identity, researchers have documented the importance of outward gender expression to the *treatment* of transgender patients for over 30 years.
37. In a series of early studies, Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals living as women – their identified gender – to those who were living as men, compared to psychiatric patients. Those who were living as women showed “a notable absence of psychopathology” while those who were living as men appeared more similar to the psychiatric patients, “underlin[ing] the importance of living as female.” (Greenberg & Laurence 1981).
38. More recently, Sevelius (2013) proposed the gender affirmation model which documented that access to gender affirming social recognition equated with better mental health, fewer suicide attempts, and lower levels of depression and posttraumatic stress disorder (PTSD) scores.

39. Denying a patient who is receiving hormone therapy the ability to outwardly express their gender is a gross departure from accepted medical standards that undermines the efficacy of treatment and can lead to sequelae such as worsening anxiety, depression, suicide ideation and auto-castration attempts.

Surgical Interventions

40. The WPATH Standards also recognize that while many individuals with gender dysphoria can experience profound relief with hormone therapy and changes in gender expression alone, for others, relief from gender dysphoria cannot be achieved absent sex reassignment surgery, or surgical interventions such as genital or chest reconstruction that change primary or secondary sex characteristics, the safety and efficacy of which are well documented in the medical literature. (Pfafflin & Junge, 1998; Smith et al., 2005; Jarolim et al., 2009, Standards of Care). Individuals with gender dysphoria are referred for surgery when they meet the eligibility and readiness criteria set forth in the Standards of Care. (Standards of Care, Section XI.)

Psychotherapy

41. Psychotherapy can provide support with the many issues that arise in tandem with gender dysphoria. However, it is imperative that mental health care providers be competent and knowledgeable about gender dysphoria. The provision of care provided by mental health professionals should be based on a determination of a client's reasons for seeking help. The overarching goal of treatment is to find ways to maximize a person's overall well-being, and to find comfort in their gender identity expression. Psychotherapy is not intended to alter a person's gender identity.

42. Counseling, however, is not a substitute for medically indicated treatment. By analogy, in diabetes, counseling might provide psychoeducation about living with a chronic condition, but it does not replace the need for insulin.
43. Similarly, treatments aimed primarily at the symptoms of anxiety or depression— e.g. anxiolytics, selective serotonin reuptake inhibitors, or mood-stabilizing psychotropic medication—do not provide relief from gender dysphoria and are not a substitute for appropriate treatment.

Healthcare Provider Minimum Qualifications

44. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated. The Standards of Care specify the qualifications professionals must meet in order to provide care to gender dysphoric patients. Licensure, without the following established competencies, does not confer competency in this specialized area irrespective of a healthcare professional's credentials, training or other experience. In particular, the Standards of Care stipulate that, along with a master's degree or equivalent in a clinical behavioral science field and documented credentials or license and documented supervised training and competence in psychotherapy or counselling, a mental health professional must have:
 - a. Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria;
 - b. The ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; and
 - c. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience, or participating in research related to gender nonconformity and gender dysphoria.
45. A review of mental health records belies any assertion that the providers who treat Ms. Diamond meet the aforementioned qualifications, or have experience in the treatment of gender dysphoria.

On 11/13/19, an MD noted: “inmate identifies as transgender male.” On 2/18/20, a note again describes Ms. Diamond, a transgender female, as identifying as a “transgender male.” It’s hard to imagine any mental health provider committing such an egregious error. A review of Ms. Diamond’s treatment plan further exposes a lack of knowledge regarding gender dysphoric patients. In fact, Ms. Diamond’s treatment plan completely neglects treatment for gender dysphoria. The plan goals stated are: “100% compliance with (psychotropic) medication”; “begin healing process from abuse”; “develop appropriate coping skills...deep breathing, thought-blocking, art, distraction, etc.” None of these interventions are efficacious or evidence-based treatment for gender dysphoria. Nor do they provide any relief whatsoever from the mental health issues attendant to gender dysphoria.

46. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care.
47. The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct directs psychologists to “provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence...” The Code of Ethics goes on to direct psychologists as follows: “Where scientific or professional knowledge in the discipline of psychology established that an understanding of factors associated with...gender [and] gender identity...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services, or they make appropriate referrals...”.

48. The Standards of Care establish that professionals who are new to the field should work under the supervision of mental health professionals with established expertise in this area. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care or place patients at significant medical risk. (Standards of Care, Section VIII).

Prison Placement Decisions

49. The Standards of Care state that housing placements for incarcerated transgender and gender-nonconforming people “should take into account their gender identity and role, physical status, dignity and personal safety,” and that institutions where “transgender[] and gender non-conforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.” (Standards of Care, Section XIV.)

50. Housing and shower/bathroom facilities for individuals with gender dysphoria in institutional settings should be in accord with their gender identity and social role. The failure to treat a woman with gender dysphoria as a woman in an institutional setting will intensify gender dysphoria and psychological distress and can precipitate psychiatric disorders.

IV. SUMMARY OF CLINICAL OBSERVATIONS AND ASSESSMENTS

51. I was initially retained by Ms. Diamond in December 2014, to conduct a clinical evaluation and assessment upon which I could tender an expert opinion in *Diamond v. Owens, et. al.*, No. 5:15-cv-00050 (M.D. Ga. 2015).

52. On January 22, 2015, I conducted a three-hour clinical assessment of Ms. Diamond at the Baldwin State Prison in Milledgeville, Georgia. My assessment consisted of a clinical interview and the administration of four standardized psychodiagnostic tests with high levels of validity and reliability:

- a. the Beck Depression Inventory-II,

- b. the Beck Anxiety Inventory,
- c. the Beck Hopelessness Scale, and
- d. the Traumatic Symptom Inventory.

53. As part of this clinical assessment, I conducted a complete sex and gender history of Ms. Diamond and obtained family, demographics, physical, education, and social information. *See Diamond v. Owens, et. al.*, No. 5:15-cv-00050 (M.D. Ga. March 5, 2015), ECF No. 49 (*Diamond D*).
54. Ms. Diamond's attorneys retained me to perform a second evaluation of Ms. Diamond following her return to custody.
55. As part of my retainer, I have reviewed all of the medical and mental health records that GDC provided to Ms. Diamond's counsel.
56. On March 12, 2021, I also conducted a one-hour assessment and performed psychodiagnostic testing of Ms. Diamond via telephone, the only means of visitation and access available to me as a result of Covid-19.
57. At the time of the evaluation, Ms. Diamond was incarcerated at Coastal State Prison.
58. Ms. Diamond was alert and oriented in all spheres, and engaged with ease. There are no disorders of thought, and thought processes are logical, goal-directed and without distortion. Memory and abstract reasoning are normal. Language was fluent, speech was natural, and voice was well modulated. Intelligence is above average (by estimation). Affect was dysthymic, mood was despondent. At times, Ms. Diamond was extremely distraught: she cried when relating the abuse she routinely endures, the lack of support she receives from the institution's providers, the failure to ensure her safety, and her feelings of hopelessness and resignation. Ms. Diamond was

completely cooperative throughout the evaluation process, and I am confident that the opinions I hereafter render are reliable and valid to a reasonable degree of medical certainty.

59. What follows is a summary of Ms. Diamond’s mental health diagnoses, treatment background, and outstanding needs, based on my clinical interviews, psychodiagnostic evaluations, and review of her medical records and case files.

Ms. Diamond’s Neuroendocrinology, Gender Dysphoria, and Physical Characteristics

60. Ashley Diamond has persistent, long-standing, severe gender dysphoria. She meets, and exceeds, the full criteria for the DSM-V diagnosis of Gender Dysphoria in Adolescents and Adults, 302.85. Historically, she had Gender Identity Disorder in Childhood, 302.6, which persisted. Ms. Diamond has the diagnostic feature often referred to as “primary” transsexualism. In these cases, the feeling of “being trapped in the wrong body” is so severe that the adolescent never even attempts to live in the birth-assigned gender. There is no controversy about her diagnosis.
61. Based on current scientific and medical knowledge and understanding, sex is composed of several components: brain phenotype, gender identity, chromosomes and the hormones they script, internal reproductive organs and external genital structures. For adults, where there is any lack of congruity among these characteristics, gender identity predominates in prioritizing these determinants.
62. There is no dispute that Ms. Diamond has a female gender identity. Accordingly, based on the contemporary scientific and medical understanding of sex, Ms. Diamond is female. The fact that she is transgender – that is, that she was ascribed the sex of male when born notwithstanding her female gender identity – does not alter that conclusion.
63. Although she was not free to express her female gender identity as a child, Ms. Diamond was aware of her cross-gender identification as early as five years old. Throughout her childhood, she had a persistent, consistent, unrelenting feeling that she was a girl and attempted to express her

female gender various times, only to be met with familial hostility and community abuse. By age 17, she began hormone therapy to alleviate the symptoms of gender dysphoria and has lived openly as female ever since – for more than 26 years.

64. Ms. Diamond’s gender dysphoria requires life-long medical care and monitoring in accordance with the treatment protocols in the Standards of Care, including with respect to hormone therapy and the requirement that she live and function as a woman.
65. Except for periods where treatment has been interrupted by GDC, Ms. Diamond has been receiving feminizing hormones to treat her gender dysphoria and to align her body with her gender identity since the age of 17.
66. Ms. Diamond has been hormonally reassigned, meaning she has the same circulating sex steroids as female peers.
67. Hormones affect every organ system in the body, including the primary and secondary sex characteristics. Hormones regulate all bodily functions. The stimulus for hormone release is complex, originating in the hypothalamus and prompting the pituitary to act on the endocrine glands: the thyroid, parathyroid, pancreas, adrenals, and gonads. Those polypeptides then circulate in the blood stream, acting on organ systems such as the pancreas, to produce insulin, which in turn acts on a cellular level, mediating the response on target organs. The roles of the hormone insulin in diabetes, or cortisol in Addison’s disease, are mundane examples of the intricate interplay of psychological and somatic disorders that rely on precisely titrated hormonal interventions.
68. Hormone therapy aligns the patient’s secondary sex characteristics with their gender identity. (*See, e.g.,* Cohen-Kettenis & Gooren, 1992). In Ms. Diamond’s case, as a result of her long-term hormone regimen, as well as her innate gender expressive characteristics, Ms. Diamond’s

physical appearance aligns with the typical characteristics of a woman of similar age and build where she has significant breast development (or gynecomastia), greatly decreased testicular size with reduction in size of external genitalia (and prostate), fat on the hips and buttocks, diminished upper body mass in chest and extremities, and limited facial and body hair—a markedly atypical male phenotype.

69. Consistent with her long-time hormone levels, Ms. Diamond has the secondary sex characteristics of a woman. She has normal female breast development, softened skin, diminution of body hair, the absence of male pattern baldness, redistribution of body fat consistent with a female shaped body, loss of muscle mass, and genital changes. Indeed, only when GDC interrupted her medically necessary treatment beginning in 2012 did she develop male pattern facial and body hair that now require medical management.
70. With prolonged hormone use, the testes will atrophy approximately 50% in size and volume, and the penis will atrophy. Long-term use of cross-sex hormones will dramatically decrease libido, and the ability to initiate or sustain an erection will cease, the equivalent of chemical castration. The testicles and penis should be examined during monitoring to assure that there is atrophy. The prostate also atrophies, which is why estrogen is often prescribed to cisgender male patients with malignant prostate disease, and there is a change in the anatomical condition of the bladder neck. (Mayo Clinic, Health Care; UCSF Information on hormone therapy, 2020; Gooren & Delemarre-van de Waal, 2007)). Ms. Diamond confirms her long-term hormone usage has thus created significant physiological changes to her genitals. That is, she has atrophy of the prostate, testicles and penis as is typical for transgender women who have been “chemically castrated” and hormonally reassigned. As a result, she does not have erections, and she is unable to initiate penetrative sex.

Ms. Diamond's Gender Dysphoria Treatment Needs

71. The longstanding medically necessary treatment for Ms. Diamond's condition has consisted of consistent access to therapeutic forms of hormone therapy, accompanied by monitoring and bloodwork that ensures her levels are in the normal physiological range for females, and the ability to live consistent with her affirmed female gender through clothing, grooming, hairstyle modifications, and use of gender-congruent pronouns. *See* First Declaration of Dr. Randi Ettner dated February 19, 2015, *Diamond v. Owens*, No. 5:15-cv-00050, ECF 2-1 ("First Ettner Declaration") at pgs. 11, 15-17; Second Declaration of Dr. Randi Ettner dated May 18, 2015, *Diamond v. Owens*, No. 5:15-cv-00050, ECF 49-2 ("Second Ettner Declaration") at pgs. 5-6.
72. The ability to wear gender congruent clothing and hairstyles, to obtain and use gender-appropriate hygiene and grooming products, to be addressed by a chosen name and to be addressed by a pronoun consistent with one's identity are considered medical elements of treatment as they reduce gender dysphoria, depression, anxiety, self-harm ideation and behavior, suicidal ideation and attempts (Russell et al, 2018). Furthermore, these elements of congruent gender expression enhance well-being and functioning (Glynn et al., 2016).
73. Ms. Diamond's healthcare providers within GDC have concurred in this assessment that the medically-indicated treatment for Ms. Diamond includes access to gender congruent female accoutrements and hormone therapy.
74. Because Ms. Diamond's hormone therapy was interrupted by GDC for a three-year period from 2012 to 2015 which promoted the first-time growth of facial and body hair, medically necessary treatment for Ms. Diamond's gender dysphoria also includes consistent and effective access to hair removal treatments (i.e. electrolysis or prescription strength depilatory creams).

Adequacy of Gender Dysphoria Management by GDC

75. My initial assessment of Ms. Diamond occurred in 2015 when Ms. Diamond's gender dysphoria treatment had been discontinued by GDC, contrary to clinical guidance, for approximately a three-year period. *See generally* First Ettner Declaration.
76. As my first evaluation of Ms. Diamond explained, the cessation of treatment by GDC led Ms. Diamond to experience depression, anxiety, suicide ideation, and to attempt auto-castration, auto-penectomy, and suicide on multiple occasions—sequelae that were documented in Ms. Diamond's GDC medical records. *See* First Ettner Declaration at pgs. 13-16.
77. Ms. Diamond was approved for hormone therapy within GDC in March 2015, but she was denied accommodations related to her gender expression and received hormone therapy in doses considered sub-therapeutic under prevailing medical standards. *See* Second Ettner Declaration at pgs. 4-6.
78. As a result, Ms. Diamond continued to experience gender dysphoria symptoms throughout her time in custody. *Id.* Ms. Diamond's gender dysphoria only became asymptomatic upon her release when she was able to resume living in accordance with her female gender identity and resume proper hormonal management.
79. Since her return to custody in October 2019, Ms. Diamond's gender dysphoria treatment needs have once again been acutely unmet.

Gender Expression

80. Integral to successful treatment of Ms. Diamond's gender dysphoria is her ability to present consistent with the affirmed gender—a crucial form of treatment that allows the patient to receive social recognition of their female gender and which in turn relieves the distress of anatomical dysphoria and identity threat.

81. To date, few accommodations have been made for Ms. Diamond's gender expression. Ms. Diamond reports that she is referred to as a man and addressed by GDC staff using male pronouns. She is not allowed to request female commissary items, a female clothing package, or to wear her hair in a feminine style. As such, Ms. Diamond remains without this necessary component of medical care.
82. The current restrictions on Ms. Diamond's ability to outwardly express her gender through grooming, use of gender-congruent pronouns, and dress greatly undermine her ability to obtain clinically significant relief from gender dysphoria, suicidal ideation, and emotional distress. (See Bockting & Coleman, 2007; Melendez & Pinto, 2007; Nuttbrock et al, 2009).
83. Ms. Diamond has resorted to attempting auto-castration. This is not an act of mutilation, but rather surgical self-treatment. Auto-castration is not uncommon in prison settings, but only occurs in the absence of appropriate or adequate medical care. (Brown, 2010). Ms. Diamond's attempt to strangulate the testicles could very likely result in necrotic infection, potentially leading to systemic infection.
84. Ms. Diamond has also made multiple suicide attempts and remains actively suicidal. The persistence of these severe dysphoria symptoms confirms the consensus view that Ms. Diamond's gender dysphoria cannot be appropriately managed without accommodations for her gender expression.
85. With appropriate hormonal therapy, accommodations for her gender expression and psychotherapy that addresses gender dysphoria, Ms. Diamond's mental health and overall well-being would be greatly improved and her suicidal ideation resulting from gender dysphoria would abate.

86. To attenuate and manage her gender dysphoria symptoms going forward, Ms. Diamond requires female clothing and grooming items. The physical changes facilitated by hormones make gender-affirming clothing and grooming items necessary not only for her mental health but also for her basic physical comfort and dignity. For example, female undergarments allow testicles to be tucked and less visible, reducing symptoms of gender dysphoria. Likewise, regardless of breast development, a bra may be an important and affirming symbol of femininity. Research indicates congruent gender expression has a significant beneficial effect on the mental health of transgender women. And in my professional experience, I have witnessed corrections departments across the country safely and effectively provide incarcerated transgender women treatment in the form of the very accommodations described here.
87. Ms. Diamond's medical records also confirm that she does not have access to electrolysis or a medically approved means of hair removal.

Hormonal Management and Monitoring

88. The lack of timely monitoring of Ms. Diamond's medical treatment is worrisome, and an indication that her providers are not proficient in this specialized area of medicine. The failure to perform essential laboratory monitoring is likely to lead to negative outcomes. The SOC state: "If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care." A review of medical records indicates that in May of 2020, Ms. Diamond was receiving 200 mg/d of spironolactone. In October of 2020, records indicate her spironolactone was reduced to 100mg/d. No clinical explanation is provided for this change in protocol, nor are there laboratory values that indicate electrolyte or potassium imbalances. Sudden changes in medical protocols require a basis in clinical and laboratory evidence that requires documentation.

89. Even with respect to this protocol, it is unclear whether Ms. Diamond is receiving timely and appropriate hormone therapy as GDC has also failed to conduct regular blood work and monitoring of Ms. Diamond's hormone levels—a serious departure from the accepted Standards of Care that puts her at risk of blood clots, electrolyte imbalance, emotional dysregulation leading to suicidal ideation, and exacerbation of gender dysphoria. Based on Ms. Diamond's medical records, the last time Ms. Diamond had labs drawn was November 26, 2019.
90. Without essential laboratory monitoring, it is impossible to know if Ms. Diamond is receiving optimal dosages of cross sex hormones or appropriate hormonal treatment. However, her current symptoms and attempts to remove her testicles to stop testosterone production are de facto evidence that she is not receiving adequate treatment.

Ms. Diamond's Post Traumatic Stress Disorder

91. During her first period of incarceration (2012-2015), Ms. Diamond was also subjected to serious sexual abuse that led her to be diagnosed with post-traumatic stress disorder (PTSD). This diagnosis is documented in Ms. Diamond's GDC medical records. I also confirmed Ms. Diamond's PTSD diagnosis in my 2015 assessments of Ms. Diamond. *See* First Ettner Declaration at pg. 12.
92. Recognizing that her PTSD was severe enough to require treatment and professional mental health resources, Ms. Diamond sought mental health trauma-informed care from a therapist who treated her at a reduced fee upon her release from custody in 2015.
93. Since her re-entry into custody in October 2019, Ms. Diamond has been subjected to sexual abuse, assaults and victimization by inmates and staff causing an exacerbation of her PTSD symptomatology and a global deterioration of functioning.
94. My current evaluation reveals that Ms. Diamond is experiencing worsening trauma symptomatology due to her re-exposure and to extremely stressful events and conditions. In

addition to intrusive experiences (B cluster in 309.81; DSM-5), (nightmares, flashbacks, upsetting memories triggered by current events), Ms. Diamond is also experiencing dissociative symptomatology (specifier, DSM-5). Dissociation can be defined as an unconscious, defensive alteration in awareness, developed as an avoidance response to overwhelming trauma and psychological distress. She exhibits suicidal ideation and suicidal behavior, and a conviction that death is the only means of escaping the highly adverse experiences she is enduring in a male correctional facility. She also exhibits the PTSD symptoms of anxious arousal (hypervigilance and hyperarousal), defensive avoidance, depressed mood and depressive cognitions.

95. When patients with PTSD are evaluated on more than once occasion it allows the clinician to determine changes over time. The deterioration in Ms. Diamond's broad-spectrum trauma symptoms is clinically concerning. The US. Department of Veterans Affairs and the National Institutes of Health recommend a higher level of evidence-based treatments when patients' symptoms worsen over time and functioning deteriorates.
96. Ms. Diamond has what is referred to as *complex trauma*, a form of PTSD. Complex trauma is a result of traumatic stressors that are interpersonal, i.e. intentionally caused and planned by humans. Interpersonal trauma results in more severe harm than random or impersonal trauma, i.e. "acts of God." Additionally, interpersonal victimization is typically repeated and chronic. Whether it occurs routinely or intermittently, the victim does not have adequate time to regain emotional equilibrium between "assaults" and the fear that another attack can occur at any time leads to states of hypervigilance and anxiety.
97. The trauma of PTSD has biological and psychological sequelae, and treatment relies on a multi-dimensional approach. Treatment, particularly for complex trauma, should be evidence-based, and must address the biological and psychological disturbances.

98. The biological pathology in PTSD is conceptualized as a dysregulation of the Hypothalamic-Pituitary-Adrenal Axis (HPA) axis and the neurocircuitry of the brain. Patients with PTSD can no longer mediate the fight-flight-freeze response, as the fear circuitry stops responding to signals from the prefrontal cortex. Medications act upon neurotransmitters in the brain to target these PTSD symptoms: intrusive thoughts, nightmares, flashbacks, negative alterations in cognitions and mood, sleep problems, hypervigilance, increased startle response and self-destructive behavior.
99. Medications minimize, but do not entirely eliminate symptoms. They are used in conjunction with trauma-specific psychotherapy. Research indicates that maximum benefit from medication depends on adequate dosage and duration of treatment. Selective serotonin reuptake inhibitors (SSRIs) are the mainstay of pharmacologic treatment, and the first line of defense. As this class of drugs will also treat major depressive disorder, some patients are maintained on SSRIs or a related class of psychotropic medication for life.
100. Psychotherapeutic treatment of complex trauma requires specific sequencing, due to the many symptoms and the necessity of the patient feeling safe. Many mental health professionals are unaware that patients can be re-traumatized if they are required to deal too soon or too directly with the traumatic experiences. Studies indicate that 14 % of patients with PTSD discontinue therapy, due to difficulty re-experiencing the trauma. Often, the patient is functioning so minimally that attendance at appointments is inconsistent.
101. Two forms of psychotherapy, cognitive-behavioral therapy (CBT) and prolonged exposure (PE), are supported by research as being efficacious for the treatment of some of the more intractable symptoms of complex trauma. However, these treatments should only be initiated after the

patient feels safe, and a therapeutic alliance has been consolidated. Best outcomes of CBT are considered to be a 50% reduction in symptoms over a 16-week period.

102. The therapy must also involve psychoeducation, so the patient can come to an understanding of reactions to trauma and begin to rebuild coping skills. Processing the trauma is a later stage of treatment and is often accomplished with a method known as Eye Movement Desensitization Reprocessing (EMDR). This requires a mental health specialist who has been trained and certified in this treatment modality.
103. There is no cure for PTSD—only treatment, as summarized above. Without prompt treatment, PTSD worsens, and even a few weeks' delay can negatively impact prognosis.
104. The ongoing sexual assaults Ms. Diamond is subjected to elicit and aggravate pre-existing trauma symptoms. Ms. Diamond's experiences of being masturbated on, raped, groped, and otherwise sexually violated, which are summarized in Ms. Diamond's complaint and which she tearfully recounted in my recent assessment, have resulted in an irremediable impairment in her sexual health, including a complete loss of libido.
105. Ms. Diamond's PTSD is now disabling. Although lay people assume that trauma heals with time, conversely, PTSD becomes more intractable and debilitating over time. Recurrent sexual assaults, abuse, intimidation, harassment, victimization and fear have eroded Ms. Diamond's resiliency, re-traumatizing her and causing irrevocable harm.
106. Ms. Diamond has also developed anxiety as a comorbid condition — a result that is consistent with the psychological literature which explains that approximately 80 percent of patients with PTSD have at least one other comorbid psychiatric disorder, with depression and anxiety disorders being the most common.

Ms. Diamond's Additional Mental Health Conditions and Symptoms Resulting from Abuse and Mistreatment Since Her Re-Entry Into GDC Custody

Major Depressive Disorder

107. Ms. Diamond meets the criteria for major depressive disorder: She experiences persistent feelings of sadness and hopelessness, sleep dysregulation, nightmares, anhedonia (loss of interest in activities that were once enjoyable), difficulty concentrating, rumination, low energy, and feelings of worthlessness. This condition is exacerbated by the assaults and abuse she has experienced since re-entering prison, GDC's failure to provide her with appropriate medical care for her gender dysphoria, and her confinement in men's prisons where she is treated as male.
108. Major depressive disorder is a serious mental disorder that profoundly affects a person's quality of life. It is the most common cause of disability and affects nearly 16% of the global population. It is closely associated with dementia, type 2 diabetes, coronary artery disease, Parkinson's disease, epilepsy, cancer, osteoporosis, and irritable bowel disease. Unfortunately, due to the chronicity and debilitation of depression, it complicates the prognosis of many chronic diseases.
109. Stressful life events can induce a series of psychological and physiological changes. Stress is an adaptation to the fight or flight response and can induce a constellation of physiological system responses (including nervous, endocrine and immune system) which can be harmful. Among those responses dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis is perhaps the most common neurobiological change in depressive patients, occurring in about 70% of patients with this disorder.
110. The Standards of Care state that mental health professionals who are competent to treat gender dysphoric patients "recognize and diagnose coexisting mental health concerns and distinguish these from gender dysphoria." When major mood disorders and gender dysphoria coexist, no anti-depressants, mood stabilizers, anti-anxiolytics or anti-psychotic medications will be

efficacious, absent treatment for the gender dysphoria. For this reason, Ms. Diamond's mental health plan *i.e.* "100% compliance with medication" will not attenuate her gender dysphoria.

Anxiety Disorder

111. The re-administration of a test that measures four clusters of anxiety, (neurophysiological, subjective, panic and autonomic) indicates that Ms. Diamond, is once again, experiencing anxiety. The intensity of the symptoms is severe. These symptoms include, for example, feeling unsteady, hands trembling, sweating (not due to heat), inability to relax, and fear "of the worst happening." This cluster of symptoms is autonomic and panic-related symptomatology of anxiety, not subject to voluntary control or cognitive reappraisal. This level of anxiety is consistent with a diagnosis of panic disorder and/or post-traumatic stress disorder. The sexual harassment and violence Ms. Diamond is subjected to, including attacks that occur while she is asleep, prompt physiological hyperarousal and a fight/flight response causing the release of catecholamines. Given the violence and unpredictability of these attacks, and her complete lack of agency, Ms. Diamond will experience a sense of helplessness which prompts suicidal behavior. This is not unlike the reactions of victims of torture (see for example, Center for Victims of Torture).
112. Anxiety can be treated with medication and psychotherapy (psychodynamic treatment refers to psychoanalytic approaches) but only in conjunction with evidence-based medical treatment of gender dysphoria. The Standard of Care addresses the need to treat co-occurring mental health conditions in tandem with treatment for gender dysphoria.

Suicide Risk

113. Similar to 2015, Ms. Diamond's responses on the Beck Hopelessness Scale underscore the severity of her current mental state. Hopelessness has been repeatedly found to be a better predictor of suicide than depression, and scores on this instrument of 9 or higher are predictive of eventual completed suicide (Beck, 1986). A study of 1,969 outpatients who were administered the Beck Hopelessness Scale found that of those who ultimately committed suicide, 93.8% had scores of 9 or higher. Ms. Diamond scored a 15 in 2015 and again currently, upon retest, indicating her extremely high risk of completing a suicide.
114. Ms. Diamond's suicidality and deteriorating mental health speak to the inadequacy of her gender dysphoria treatment, the impact of her custodial sexual assaults, and the ongoing stressors of her environment as a woman in a men's prison.
115. Several lines of research suggest that individuals like Ms. Diamond who attempt suicide on multiple occasions are far more likely to die by suicide than are single attempters. Miranda, R., Scott, M., Hicks, R., Wilcox, H., Munfakh, J., & Schaffer, D. (2008). *Suicide attempt characteristics, diagnoses, and future attempts: comparing multiple attempters to single attempters and ideators*. *Journal of American Academy of Child and Adolescent Psychiatry*. 47(1):32-40.

The Impact of Ms. Diamond's Housing Placements on Her Psychological Well-Being

116. My clinical assessment and review of Ms. Diamond's medical records make clear that having lived her entire adult life as a female, it is unbearable for Ms. Diamond to now be forced to live as a man and be treated as a man.
117. Ms. Diamond's female phenotype (her outward appearance) makes life in male prisons, where she is treated as a man by staff and as a sexual object by incarcerated men, an untenable

situation. It is now medically necessary that she be transferred to a female correctional facility, where she will not be in danger of violent sexual assault by men.

118. Not only has Ms. Diamond been the victim of repeated rapes and sexual assaults, she is a transgender woman who is viewed naked and in states of undress by male inmates and staff on a near daily basis; strip-searched by male guards; groped and pushed up against by men; the target and object of men who masturbate over her and while looking at her multiple times a week, sometimes daily; forced to shower in view of male prisoners who view her as a sex object; referred to as a “he,” “it” and a “freak”; referred to with male pronouns; and lives in a constant state of hypervigilance for the next sexual assault, attack and victimization -- all of which creates profound and debilitating mental distress that Ms. Diamond, as would most women, experiences as torture.
119. The Standards of Care also confirm that placement of individuals in male or female facilities should be made on a case-by case basis, rather than on the basis of sex assigned at birth or a person’s surgical history, with an eye towards safety and climate, to minimize interference with healthcare treatment or the risk of attacks. (Standards of Care, Section XIV.)
120. It is my understanding that, consistent with this guidance, the Federal Bureau of Prisons and state corrections departments across the country have also begun housing transgender women in female facilities on a case-by-case basis in consideration for their safety.
121. In my expert opinion, having evaluated several other transgender women to determine their eligibility for transfer or rehousing at female facilities, I am not aware of any reason Ms. Diamond could not be safely placed in a female correctional facility. The evidence available to me suggests that Ms. Diamond poses no danger to female prisoners and would be capable of living harmoniously in a female population.

122. Ms. Diamond is a pleasant, non-aggressive person, with no history of violence towards others. I also have personal knowledge of a number of other transgender women who have been successfully housed in female prisons without endangering the safety of others.
123. The hopelessness and despair Ms. Diamond is experiencing as a woman forced to live in men's prisons has put her at elevated risk of completing a suicide. Ms. Diamond has indicated that she would end her life today, without hesitation, provided that she had the means. Research confirms that persistent suicide ideation and prior suicide attempts are the greatest risk factors for eventual death by suicide.
124. Therefore, it is clinically imperative to attend to Ms. Diamond's suicide risk, which will be best managed if she is provided a safe and appropriate housing placement that reduces her exposure to sexual violence and threats and supports her gender expression in a manner that attenuates both her gender dysphoria and PTSD symptoms.

V. CONCLUSION

125. Since her 2019 return to GDC custody, Ms. Diamond has not received medically necessary or medically adequate treatment for her gender dysphoria, which for Ms. Diamond entails:
- a. Consistent access to therapeutic levels of hormone therapy, with levels confirmed through regular monitoring,
 - b. Accommodations that allow her to live consistent with her affirmed gender (i.e. clothing and grooming allowances, gender-congruent pronouns), and
 - c. Consistent and effective access to hair removal treatments that resolve facial and body hair (i.e. electrolysis or prescription strength depilatory creams).
126. These treatment failures flout the accepted Standards of Care, and have caused Ms. Diamond significant physical and psychological harm. Ms. Diamond's resilience has eroded and she has experienced a rapid deterioration of her mental health, including a global deterioration of functioning and an ingravescent course of psychological decompensation. Ms. Diamond is also

experiencing severe depression, anxiety, and suicidal ideation. Ms. Diamond has also attempted auto-castration and suicide on numerous occasions, and continues to express a desire to end her life.

127. My clinical opinion is that Ms. Diamond will remain at extreme risk for psychological decompensation and/or suicide until her gender dysphoria treatment needs are met. Thus, to remediate these harms, I recommend that the full complement of medical treatment specified above be immediately initiated without delay.
128. Ms. Diamond has also experienced worsening PTSD, anxiety, and trauma symptoms because of the abuse and attacks that she has experienced and continues to experience in GDC custody as a woman being forced to live in men's prisons. Ms. Diamond recounted that she is currently housed with males, strip searched by males, and is often viewed naked by male inmates and staff. She related that even during a simple haircut she was subjected to an aroused penis flanking her back. This unremitting victimization has resulted in severe and potentially catastrophic psychological harm, as Ms. Diamond increasingly believes she can only escape her unbearable living environment by death, and welcomes this result.
129. In my clinical opinion, Ms. Diamond's PTSD, anxiety, and trauma symptoms will not abate so long as she remains housed in male facilities where she faces unyielding abuse and threats, along with constant triggers and reminders of past assaults. Stated another way, Ms. Diamond's PTSD and gender dysphoria symptoms would significantly improve if she were placed in a women's prison where her gender identity and expression are accommodated and affirmed.
130. While some trauma and anxiety symptoms may now be intractable, they will be attenuated in an environment where her female gender identity does not serve as the basis for unending sexual

violence and attacks. Accordingly, Ms. Diamond should be prioritized for placement and transfer in a women's facility in accordance with GDC's existing criteria.

131. It is medically indicated that Ms. Diamond receive essential care for gender dysphoria and a facility transfer for purposes of safety. However, as was the case in 2015, the results of inadequate treatment are predictable and dire, and take one of three paths: profound emotional decompensation, surgical self-treatment, or suicide.

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

Dated: *March 29, 2021*

Respectfully submitted,

Dr. Randi C. Ettner

Dr. Randi C. Ettner

APPENDIX A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago, IL
Advisory Council, National Center for Gender Spectrum Health

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

- 2016-present Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
Consultant: Walgreens; Tawani Enterprises
Private practitioner
- 2011 Instructor, Prescott College: Gender-A multidimensional approach
- 2000 Instructor, Illinois Professional School of Psychology
- 1995-present Supervision of clinicians in counseling gender non conforming clients
- 1993 Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
- 1992 Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
- 1983-1984 Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
- 1981-1984 Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
- 1976-1978 Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1975-1977 Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1971 Research Associate, Department of Psychology, Indiana University
- 1970-1972 Teaching Assistant in Experimental and Introductory Psychology
Department of Psychology, Indiana University
- 1969-1971 Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Care of the Older Transgender Patient, Weiss Memorial Hospital, Chicago, IL, 2021

Working with Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Columbia, MO, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

*Pre-operative evaluation in gender-affirming surgery-*American Society of Plastic Surgeons, Boston, MA, 2015

*Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-*Fenway Health Clinic, Boston, 2015

Gender reassignment surgery- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; Care of the aging transgender patient- University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

*Children of Transsexuals-*International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

*Gender Identity, Gender Dysphoria and Clinical Issues –*WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychoneuroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

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PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

University of Minnesota, Program of Human Sexuality *50 Sex and Gender Revolutionaries* award, 2021
Letter of commendation from United States Congress for contributions to public health in Illinois, 2019
WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women’s Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

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