IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

CRISTINA NICHOLE IGLESIAS
(a.k.a. CRISTIAN NOEL IGLESIAS),

Plaintiff,

v.

IAN CONNORS, *et al.*,

Defendants.

Case No. 19-cv-00415-RJN

Judge Nancy J. Rosenstengel

PLAINTIFF'S MOTION AND MEMORANDUM IN SUPPORT OF A PRELIMINARY INJUNCTION

Plaintiff Cristina Nichole Iglesias is a transgender woman in the custody of the Federal Bureau of Prisons ("BOP") at Federal Correctional Institution-Fort Dix ("Fort Dix"), a men's prison. Her life is at risk. She moves for a preliminary injunction to address Defendants' failures to provide adequate care for gender dysphoria—a serious medical condition—and to protect her from mental anguish, sexual assault, and physical violence. Defendants continue to deny Plaintiff medically necessary treatment, including gender confirmation surgery ("GCS"), permanent hair removal, and transfer to a female facility. She has also been repeatedly raped and assaulted at Fort Dix, as at previous facilities, and is under continuous and serious threats to her life and safety. Because of the violence she experiences as a woman in a men's facility, she is now isolated in protective custody as her only means of survival. In past weeks, Ms. Iglesias has again considered life-threatening self-harm. In the absence of preliminary relief, she will suffer irreparable harm.

STATEMENT OF FACTS

I. Procedural Status

Ms. Iglesias filed a pro se complaint in April 2019 seeking injunctive relief and damages. (ECF No. 1). On July 14, 2019, the Court's Initial Screening Order permitted Plaintiff to proceed

on claims against certain Defendants. (ECF No. 40). On February 20, 2020, Plaintiff was appointed counsel. *Id*. On September 8, 2020, Plaintiff filed her First Amended Complaint ("FAC") (ECF No. 52), limiting her claim to injunctive relief. On October 29, 2020, this Court entered a screening order allowing the FAC to move forward but dismissing the BOP without prejudice. (ECF No. 70). On November 9, 2020, Plaintiff moved for reconsideration to restore the BOP as a defendant. (ECF No. 74). On February 24, 2021, Plaintiff sought leave to file a seconded amended complaint with the BOP as a defendant. (ECF No. 85).[1] All parties currently agree that the BOP should be a party. (ECF Nos. 76 & 89).

II. Plaintiff's History of Gender Dysphoria

Ms. Iglesias is a transgender woman—an individual whose female gender identity differs from the male sex assigned to her at birth. Declaration of Dr. Randi Ettner ("Ettner Decl.") at ¶ 77; Declaration of Cristina Nichole Iglesias ("Iglesias Decl.") at ¶ 3. She was aware of her female identity from a very young age and understood that her body and sex assigned at birth did not match her true identity. Iglesias Decl. at ¶¶ 2−3. At age twelve, Ms. Iglesias expressed to her mother a desire for GCS so she could live as a girl. *Id.* at ¶ 3. After withdrawing from school in tenth grade, Ms. Iglesias began to socially transition by wearing stereotypically feminine hairstyles and clothing and by taking hormonal birth control to develop breasts. *Id.* at ¶ 4.

Ms. Iglesias entered BOP custody in 1994. *Id.* at ¶ 6. In or around 1994, Ms. Iglesias was diagnosed with gender identity disorder by BOP psychologist Dr. Brian Gray. *Id.* at ¶ 7. In 2015,

[1] Plaintiff has supported this motion with the evidence available to her. She and her counsel have attempted to get copies of her medical records from BOP since Plaintiff was appointed representation, to no avail. Plaintiff's counsel requested assistance in obtaining those records from counsel for Defendants as early as November 2020 and served discovery on Defendants in December 2020, but Defendants have refused to respond at this time. Counsel also filed a Freedom of Information Act request on January 4, 2021 but has received no response. Ms. Iglesias also requested her BOP Central Office medical records but has not received a response or the records.

BOP updated Ms. Iglesias's diagnosis to gender dysphoria to reflect changes in the Diagnostic and Statistical Manual Version 5 ("DSM-5"), published in 2013. *Id.*

III. Standards of Care for the Treatment of Gender Dysphoria

Gender dysphoria is a serious condition that is characterized by a marked incongruence between the sex assigned at birth and a person's gender identity, strong cross-gender identification, and clinically significant distress or impairment of functioning. Ettner Decl. at ¶ 21. The condition is recognized by the American Psychiatric Association and listed in the DSM-5 and the World Health Organization's International Classification of Diseases-10. *Id*. at ¶¶ 19−20. Like many medical conditions, gender dysphoria can be ameliorated or cured through treatment. *Id.* at ¶ 26.

The World Professional Association for Transgender Health ("WPATH"), the leading authority on transgender healthcare, publishes internationally accepted Standards of Care ("SOC") for treating gender dysphoria. *Id.* The current SOC, published in 2011, are the prevailing standard of care for medical professionals treating gender dysphoria. *Id.*; *see De'lonta v. Johnson*, 708 F. 3d 520, 522−23 (4th Cir. 2013); *Hicklin v. Precynthe*, No. 4:16-cv-01357-NCC, 2018 WL 806764, at *3 (E.D. Mo. May 22, 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1186 (N.D. Cal. 2015); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231 (D. Mass. 2012).

The WPATH SOC set forth individualized and patient-centric medical treatment options for gender dysphoria. Ettner Decl. at ¶¶ 27, 31−34. In addition to living in accordance with the person's gender identity, treatment may include hormone therapy, surgery to change primary and/or secondary characteristics, and psychotherapy. *Id.* at ¶ 27. The SOC "explain that some individuals are unable to obtain relief from gender dysphoria without surgical intervention, and describe sex-reassignment surgery . . . as 'essential and medically necessary' for this group of

patients." *Norsworthy*, 87 F. Supp. 3d at 1186 (quoting WPATH SOC at 36); Ettner Decl. at ¶ 44. The WPATH SOC apply to both incarcerated and non-incarcerated people. Ettner Decl. at ¶ 28.

IV. Defendants' Inadequate Treatment of Plaintiff's Gender Dysphoria and Refusal to Transfer Her to a Female Facility

Ms. Iglesias requested hormone therapy from BOP medical staff in 2011 but was denied that treatment until 2015. Iglesias Decl. at ¶ 8. Since 2016, Ms. Iglesias has made requests for GCS to treat her gender dysphoria to BOP staff, Dr. Randall Pass, the United States Penitentiary at Marion ("USP-Marion") clinical team, and L.J.W. Hollingsworth, the former USP-Marion warden. *Id.* at ¶ 14. Dr. Pass, USP-Marion's clinical director, confirmed that Ms. Iglesias met the WPATH criteria for, and should receive, GCS. *Id.* at ¶ 15.

In November 2019, Ms. Iglesias was transferred from USP-Marion to Federal Medical Center-Lexington ("FMC-Lexington"). *Id.* at ¶ 18. Ms. Iglesias was told that she was being transferred there to receive GCS. *Id.* However, she was told after she arrived that no surgeons in Kentucky performed the GCS she required. *Id.* At a December 18, 2019 consultation with nurse practitioner Tammy Thomas at the University of Kentucky HealthCare's Endocrinology Department, Ms. Thomas evaluated Ms. Iglesias and concluded that she met the WPATH standards for GCS and should receive GCS. *Id.* at ¶ 20.

Ms. Iglesias formally appealed several denials she received for GCS. *Id.* at ¶¶ 16, 19. In January 2018, she appealed Warden Hollingsworth's and the Regional Director's denials of her request for GCS to the Central Office Administrative Remedies Division ("COARD"). *Id.* at ¶ 16. On March 2, 2018, Defendant Connors—National Inmate Appeals Administrator, Office of the General Counsel for BOP—acknowledged receipt by BOP's Transgender Clinical Care Team ("TCCT") of her request for GCS and indicated that he would defer to TCCT to make a decision, which Ms. Iglesias never received. *Id.* In December 2019, Ms. Iglesias again appealed her GCS

denial to the COARD. *Id.* at ¶ 19. Defendant Connors issued BOP's response to this appeal, which stated that Ms. Iglesias could not have GCS because she did not meet the requirements to be transferred to a female facility and her hormone levels "have not been maximized or stabilized." *Id.* at ¶ 21.

Ms. Iglesias also requires permanent hair removal as part of treatment for gender dysphoria. *Id.* at ¶ 22. This request was denied by Warden Hollingsworth and BOP's regional director. *Id.* at ¶ 23. Ms. Iglesias appealed the denial in March 2018. *Id*. Her appeal was denied on the grounds that she had not reported major emotional or environmental problems during her last visit with psychological services and that no provider recommended hair removal. *Id.*

Lastly, Ms. Iglesias has repeatedly requested transfer to a female facility for her safety and as part of treatment for gender dysphoria. *Id.* at ¶ 24. In November 2016, Ms. Iglesias requested a transfer by writing then-Attorney General Loretta Lynch. *Id.* at ¶ 25. Her request was forwarded to the warden at Federal Correctional Complex-Butner. *Id.* In December 2016, she received notification that her transfer request was "under review as part of an ongoing process." *Id.* at ¶ 26. On May 31, 2017, Ms. Iglesias appealed the BOP Regional Director's denial of her request for transfer to a women's facility. *Id.* at ¶ 27. She explained that she required transfer for her safety and health. *Id.* In July 2017, Defendant Connors notified her that her appeal was denied, in part because it was repetitive of earlier appeals. *Id.* at ¶ 28. In March 2020, Defendant Connors again denied Ms. Iglesias's transfer request, stating that "surgery is created after real world experience in your preferred gender." *Id.* Later that month, Ms. Iglesias applied for transfer to the women's facility at FMC-Lexington by sending a request to the warden of that facility. *Id.* at ¶ 30. Moreover, since May 2018, placements of transgender prisoners have been based at least initially on a

person's sex assigned at birth, such that any contrary placement based on gender identity "would be appropriate only in rare cases." *See* BOP Change Notice No. 5200.04 CN-1.[2]

Inadequate treatment exacerbates the symptoms related to gender dysphoria and puts the patient at a greater risk of self-harm. Ettner Decl. at ¶¶ 70, 72−73. Some individuals who do who not receive adequate medical care for their gender dysphoria become so desperate for treatment that they attempt life-threatening self-surgery. *Id.* at ¶ 70. Ms. Iglesias has engaged in self-treatment by attempting to remove her testicles and penis. Iglesias Decl. at ¶ 11. Ms. Iglesias was diagnosed with gender identity disorder in 1994 while in BOP custody; gender dysphoria is a condition that intensifies with age, causing her increasingly greater distress. *Id.*; Ettner Decl. at ¶ 71. Overall, Ms. Iglesias's gender dysphoria treatment "appears to fall far outside of what is recommended by the SOC." Ettner Decl. at ¶ 80.

V. Defendant's Failure to Protect Plaintiff from Physical and Sexual Violence

Since entering BOP custody in 1994, Ms. Iglesias has been housed in male prisons. Iglesias Decl. at ¶ 6. Throughout her time in BOP custody, Ms. Iglesias has been subjected to extensive sexual abuse, physical abuse, and harassment by BOP staff and other prisoners. *Id.* at ¶¶ 31−44. Prisoners frequently expose themselves to her, grope her, and demean her in other ways, including demanding to see her breasts. *Id.* at ¶ 36. Ms. Iglesias has reported numerous instances of abuse and harassment in 2001, 2013, 2015, 2016, 2017, 2019, and 2020. (*See* Ex. 8, June 16, 2017 BOP Psych. Services Report at 1; Ex. 9, Nov.22, 2019 BOP Health Services Report at 3-4; Ex.10, Feb. 25, 2020 Client Medical Record at 9); Iglesias Decl. at ¶ 34.

In January 2020, Ms. Iglesias was held hostage by her male FMC-Lexington cellmate because he did not want to be housed with a transgender woman, until prison staff used force to

[2] https://www.bop.gov/policy/progstat/5200-04-cn-1.pdf.

remove him. Iglesias Decl. at ¶ 39. When Ms. Iglesias refused to allow a different male prisoner at FMC-Lexington to prostitute her, he placed a "hit" on her, offering $500 to another inmate for the chance to be alone with her and hurt her. *Id.* at ¶ 41. BOP staff entered a separation order between the prisoner and Ms. Iglesias, but her safety remained at serious risk as a transgender woman in a facility where this prisoner and other men are housed. *Id.*

Because of the threats she faced at FMC-Lexington, Ms. Iglesias was transferred to Fort Dix on December 14, 2021. *Id.* at ¶ 44. She was first housed in Unit 5703 as part of the COVID-19 quarantine process but was moved in or around mid-February 2021 to Unit 5702, which is a general-population unit with capacity for three hundred prisoners. *Id.* at ¶¶ 45, 46. The unit has multiple floors with stairways connecting each floor, and each floor has an open floorplan with two-person bunk beds spaced throughout the floor. *Id.* at ¶ 46.

After entering Unit 5702, a male inmate, Osvaldo Rosa, approached Ms. Iglesias because she is a transgender woman and began to threaten her with harm if she did not engage in sex and pay him money. *Id.* at ¶¶ 47−55, 64−66. Mr. Rosa was a leader of an active gang at Fort Dix called the Ñetas. *Id.* at ¶ 47. He and another Ñetas leader, "Mejía," both demanded sex and money from Ms. Iglesias. *Id.* at ¶¶ 47, 51−53. In general, Ms. Iglesias is extremely vulnerable while housed with male prisoners because she is a woman with feminine characteristics, such as breasts, which make her a target for rape and forced prostitution. *Id*. at ¶¶ 31, 40, 46; Ettner Decl. at ¶¶ 66, 82.

Threats to Ms. Iglesias's life and safety intensified in February and March 2021. Iglesias Decl. at ¶¶ 47−48. Mr. Rosa threatened her with homemade knives to demonstrate the seriousness of his threats. *Id.* at ¶¶ 49, 51. He demanded that she pay him through a cell-phone application and call her friends and family to collect money to send to him. *Id.* at ¶¶ 49−51. To date, Mr. Rosa has extorted Ms. Iglesias for approximately $8,000. *Id.* at ¶ 50.

Mr. Rosa and Mejía repeatedly raped Ms. Iglesias and forced her to show her breasts to other prisoners. *Id.* at ¶¶ 51−53. Mr. Rosa forced her to perform oral sex on him on four occasions. *Id.* at ¶ 51. On the last occasion, Mr. Rosa held her at knife point. *Id.* Mejía raped Ms. Iglesias by forcing her to engage in anal sex. *Id.* at ¶ 52. Ms. Iglesias was also forced to show her breasts to other prisoners. *Id.* at ¶ 53. Ms. Iglesias was scared to file an internal grievance about the extortion and physical and sexual violence because Fort Dix is an open facility, making it impossible for her to avoid contact with male prisoners, including Mr. Rosa, Mejía, and other Ñetas members. *Id.* at ¶ 54. Ms. Iglesias also feared retaliation from staff. *Id.*

On or about March 4, 2021, Mr. Rosa told Ms. Iglesias that she would be killed if she did not pay him $2,000. *Id.* at ¶ 55. She then filed an online complaint with the United States Department of Justice Sexual Abuse Reporting System, requested protective custody ("PC"), and filed PREA complaints against Mr. Rosa and Mejía, detailing the extortion and physical and sexual violence. *Id.* ¶ at 57. She spoke to Lieutenant Morales, a Unit 5702 supervisor, about the PREA complaints, and medical staff gave her HIV-prophylaxis medication. *Id.*

On or about March 5, 2021, Ms. Iglesias was moved to Unit 5751, a three-story unit in which each prisoner is in a cell accessible to all others through the stairwells. *Id.* at ¶ 59. She feared for her life in this unit because there were Ñetas members in the unit who could communicate by cell phone with Mr. Rosa. *Id*. On March 5, 2021, Ms. Iglesias was moved to PC, where she remains. *Id.* at ¶ 63. Soon thereafter, Mr. Rosa was also placed in PC, where he continued to harass Ms. Iglesias. *Id.* at ¶ 64. He repeatedly shouted threats to her, told other prisoners that she was a snitch, and disclosed contact information for her friends and family members. *Id.* Though Mr. Rosa was released from prison on March 17, 2021, Ms. Iglesias continues to live in constant fear for her life because she remains in a male prison with prisoners who have threatened and assaulted her, such

as Mejía. *Id.* at ¶¶ 66−68. Due to the trauma she experiences from being denied necessary medical care and kept in BOP male facilities, Ms. Iglesias suffers from anxiety, panic attacks, sleeplessness, and loss of appetite. *Id.* at ¶ 68. She must talk herself out of committing self-harm or ending her life every day. *Id.*

LEGAL STANDARD

A plaintiff seeking a preliminary injunction must establish that (1) her claim has "some likelihood" of succeeding on the merits; (2) traditional legal remedies are inadequate; and (3) she will suffer "irreparable harm" without such relief. *Harlan v. Scholz*, 866 F.3d 754, 758 (7th Cir. 2017). If the plaintiff meets this burden, the court then weighs "the harm the plaintiff will suffer without an injunction against the harm defendant will suffer with one" and considers whether an injunction is in the "public interest." *Id.*; *see also Ty, Inc. v. Jones Grp. Inc.*, 237 F.3d 891, 895 (7th Cir. 2001).

Under the Prison Litigation Reform Act ("PLRA"), a preliminary injunction must be "narrowly drawn, extend no further than necessary to correct the harm[,] . . . and be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2). Plaintiff seeks that Defendants cease their policies and practices that expose her to ongoing violence and abuse in men's facilities and that they provide her with medically necessary care to treat her gender dysphoria. Insofar as it may require affirmative acts by Defendants, the preliminary injunction is mandatory. *See Graham v. Med. Mut. of Ohio*, 130 F.3d 293, 295 (7th Cir. 1997).

ARGUMENT

Plaintiff's current situation satisfies the necessary elements for preliminary injunctive relief. First, Plaintiff has a strong likelihood of success on the merits of her constitutional claims challenging Defendants' continued violation of her Eighth and Fifth Amendment rights. Second,

there is no adequate remedy at law; an injunction from this Court is necessary to prevent ongoing harm. Third, unless this Court provides injunctive relief, Plaintiff will continue to suffer irreparable physical and psychological harm. Finally, the balance of harms and public interest both compel an injunction. At this stage, only this Court can ensure that Plaintiff is provided safe and appropriate treatment, including transfer to a women's facility.

I. Plaintiff Has a Substantial Likelihood of Success on the Merits of Her Claims.

To establish the first element, Plaintiff need only establish "any likelihood of success—in other words, a greater than negligible chance of winning." *AM General Corp. v. DaimlerChrysler Corp*., 311 F.3d 796, 804 (7th Cir. 2002). Here, Plaintiff easily satisfies this "low threshold" with respect to each of her three constitutional claims. *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ*., 858 F.3d 1034, 1046 (7th Cir. 2017).

A. Defendants Are Deliberately Indifferent in Denying Plaintiff Medically Necessary Care for Gender Dysphoria, Including Social Transition.

Plaintiff has a strong likelihood of success on the merits of her claim that Defendants deny her medically necessary care in violation of the Eighth Amendment. Deliberate indifference to a prisoner's "serious medical needs" is unconstitutional because "it constitutes the unnecessary and wanton infliction of pain." *Helling v. McKinney*, 509 U.S. 25, 32 (1993) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). Federal courts have consistently held that a prison's failure to provide adequate treatment for gender dysphoria is deliberate indifference sufficient to justify preliminary injunctive relief. *See Monroe v. Baldwin*, 424 F. Supp. 3d 526, 547 (S.D. Ill. 2019) (granting a preliminary injunction ordering a prison system to, among other things, "develop a policy to allow transgender inmates medically necessary social transition, including individualized placement determinations"); *Edmo v. Idaho Dep't of Corr*., 358 F. Supp. 3d 1103, 1129 (D. Idaho 2018) (granting a preliminary injunction ordering that a transgender prisoner be provided

"adequate medical care, including gender confirmation surgery"); *Hicklin v. Precynthe*, No. 4:16-cv-01357-NCC, 2018 WL 806764, at *15 (E.D. Mo. Feb. 9, 2018) (granting a preliminary injunction ordering that a transgender prisoner be provided "care that her doctors deem to be medically necessary treatment for her gender dysphoria, including . . . access to permanent body hair removal"); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1195 (N.D. Cal. 2015) (granting a preliminary injunction ordering that a transgender prisoner be provided "adequate medical care, including sex reassignment surgery . . . as promptly as possible"); *see also Edmo v. Corizon, Inc.*, 935 F.3d 757, 792−94 (9th Cir. 2019) (upholding an injunction based on a deliberate-indifference claim challenging the denial of GCS); *De'lonta v. Johnson*, 708 F.3d 520, 525−26 (4th Cir. 2013) (reversing a district court's dismissal of a transgender prisoner's deliberate-indifference claim challenging the denial of GCS).

To succeed on a deliberate-indifference claim, a plaintiff must establish both objective and subjective elements. *See Greeno v. Daley*, 414 F.3d 645, 652−53 (7th Cir. 2005). To satisfy the objective element, a plaintiff must demonstrate that her medical condition is "objectively, sufficiently serious." *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). Defendants diagnosed Plaintiff with gender identity disorder in or around 1994 and later updated the diagnosis to gender dysphoria in 2015. Iglesias Decl. at ¶ 7. Since 1987, the Seventh Circuit has recognized that gender dysphoria is a "serious medical need" in deliberate indifference inquiries. *See, e.g.*, *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987); *see also Mitchell v. Kallas*, 895 F.3d 492, 498 (7th Cir. 2018); *Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011).

To satisfy the subjective element, a plaintiff must show that prison officials acted with a "sufficiently culpable state of mind," meaning they "knew of a substantial risk of harm to the inmate and disregarded the risk." *Greeno*, 414 F.3d at 653 (quoting *Farmer*, 511 U.S. at 834).

Defendants have long been aware of Plaintiff's gender dysphoria diagnosis, but routinely and deliberately disregard the substantial risk of harm to Plaintiff's health caused by their denial of Plaintiff's medically necessary care for gender dysphoria, including permanent hair removal and GCS. Iglesias Decl. at ¶¶ 12−23; *see Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011) ("Refusing to provide effective treatment for a serious medical condition serves no valid penological purpose and amounts to torture.").

Currently, Plaintiff's treatment is further compromised by her placement in PC segregation, where Defendants knowingly deny her even the ability to shave more than once per week; this leaves her with facial hair that is "deeply disturbing" for her. Iglesias Decl. at ¶¶ 24−43, 63. Social transition, which involves "grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity," is medically necessary for gender dysphoria treatment. Ettner Decl. at ¶ 36. Defendants' refusal to allow Plaintiff to shave and provide other medically necessary treatment for gender dysphoria "ignore[s] a request for medical assistance" and thus supports an inference of deliberate indifference. *Petties v. Carter*, 836 F.3d 722, 729 (7th Cir. 2016).

Left inadequately treated, Plaintiff's gender dysphoria will worsen, with harmful and potentially fatal consequences. Ettner Decl. at ¶ 72−75, 86. Because "[t]he Eighth Amendment protects [prisoners] not only from deliberate indifference to [their] *current* serious health problems, but also from deliberate indifference to conditions posing an unreasonable risk of serious damage to *future* health," this pattern of inadequate care underscores Defendants' ongoing constitutional harms. *Board v. Farnham*, 394 F.3d 469, 479 (7th Cir. 2005); *see Monroe*, 424 F. Supp. 3d at 545.

B. Defendants Unlawfully Discriminate on the Basis of Sex by Failing to House Plaintiff in a Women's Facility.

Plaintiff also has a strong likelihood of success on the merits of her equal-protection claim under the Fifth Amendment. Defendants' insistence on housing Plaintiff in a men's facility because she was assigned male at birth unlawfully discriminates against her based on her transgender status and sex. This sex-based classification triggers intermediate scrutiny. *See Bostock v. Clayton Cty., Ga.*, 140 S. Ct. 1731, 1737 (2020) (finding that acts taken due to transgender status are based on sex); *Hampton v. Baldwin*, No. 3:18-CV-550-NJR-RJD, 2018 WL 5830730, at *11 (S.D. Ill. Nov. 7, 2018) (applying intermediate scrutiny to a sex-based classification when "inmates are, by default, placed in a facility based on their genitalia"). Federal courts also recognize transgender people as a protected class under equal-protection analysis and thus subject policies based on transgender status, such as Defendants' prison-placement policy, to heightened scrutiny. *See, e.g.*, *Ray v. McCloud*, No. 2:18-CV-272, 2020 WL 8172750, at *8−9 (S.D. Ohio Dec. 16, 2020).

Under intermediate scrutiny, Defendants must proffer an "exceedingly persuasive" justification for their sex-based housing policies for transgender prisoners like Plaintiff. *Whitaker ex rel. Whitaker,* 858 F.3d at 1050 (quoting *United States v. Virginia*, 518 U.S. 515, 533 (1996)). However, "generalized concerns for prison security are insufficient to meet the 'demanding' burden placed on [Defendants] to justify sex-based classifications." *Doe v. Mass. Dep't of Corr.*, No. 17-12255-RGS, 2018 WL 2994403, at *10 (D. Mass. June 14, 2018) (quoting *Virginia*, 518 U.S. at 531). Federal courts have therefore consistently declined to recognize that placing transgender women in men's prisons substantially furthers an important government interest. *See Tay v. Dennison*, 457 F. Supp. 3d 657, 682 (S.D. Ill. 2020) (noting that assigning a transgender woman to a *women's* prison serves government interests in protecting her from sexual assault and

harassment and in promoting her safety); *Hampton*, 2018 WL 5830730, at *12; *Doe*, 2018 WL 2994403, at *9.

Separately, the rampant sexual harassment that Plaintiff experiences from prisoners and staff in male prisons also violates the Fifth Amendment's equal-protection guarantee. Plaintiff is verbally harassed, threatened, and physically and sexually assaulted. Iglesias Decl. at ¶¶ 32−38, 42, 51−53. She is also frequently misgendered by other prisoners and prison staff. *Id*. at ¶ 43. This conduct satisfies both elements of an equal-protection sexual-harassment claim. *See Trautvetter v. Quick*, 916 F.2d 1140, 1149 (7th Cir. 1990). First, the frequent harassment Plaintiff endures based on her gender identity is intentional and based on sex. *Id*. Second, such harassment is "sufficiently severe and pervasive" as to be unconstitutional. *Id.* (internal quotation marks omitted); *see Tay*, 457 F. Supp. 3d at 682−84 (finding that a transgender woman's equal-protection claim based on verbal and physical harassment in a male prison was likely to succeed); *Hampton*, 2018 WL 5830730, at *12 (finding that a transgender woman's equal-protection claim based on verbal harassment in a male prison was likely to succeed).

C. Defendants Subject Plaintiff to Cruel and Unusual Punishment by Failing to Protect Her, Placing Her at Serious Ongoing Risk of Bodily Harm.

Plaintiff has a strong likelihood of success on the merits of her claim that Defendants are failing to protect her from the constant risk of bodily harm, in violation of the Eighth Amendment. "Prison officials have a duty under the Eighth Amendment 'to protect prisoners from violence at the hands of other prisoners,' and, by extension, correctional officers." *Tay*, 457 F. Supp. 3d at 684 (quoting *Farmer*, 511 U.S. at 833); *see Hampton*, 2018 WL 5830730, at *13. To succeed on a failure-to-protect claim, a plaintiff must establish both objective and subjective elements.

First, Plaintiff must show that she is objectively "incarcerated under conditions posing a substantial risk of serious harm." *Farmer*, 511 U.S. at 834. The conditions in which Defendants

continue to hold Plaintiff plainly constitute "serious deprivations of basic human needs" and deny her "the minimal civilized measure of life's necessities," thus creating an egregious risk to her health and safety. *McNeil v. Lane*, 16 F.3d 123, 125 (7th Cir. 1993) (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)). While housed with male prisoners in male facilities, Plaintiff continuously endures a range of targeted violence. She has been subjected to multiple instances of rape and sexual assault by other prisoners. Iglesias Decl. at ¶¶ 34, 38, 51−52; *see Brown v. Budz*, 398 F.3d 904, 910 (7th Cir. 2005) (noting that physical assault by a fellow detainee "clearly constitutes serious harm"). She has been forced to display her breasts to other prisoners, is sexually harassed by prisoners and guards, and lives in constant fear for her life. Iglesias Decl. at ¶¶ 32, 35, 53, 68. A plaintiff can also "establish exposure to a significantly serious risk of harm by showing that [s]he belongs to an identifiable group of prisoners who are frequently singled out for violent attack by other inmates." *Farmer*, 511 U.S. at 843 (internal quotation marks omitted). Transgender women in men's facilities are such a group, as Plaintiff's own experience of violent attacks substantiates. *See Perkins v. Martin*, No. 3:14-cv-00191-SMY-PMF, 2016 WL 3670564, at *3 (S.D. Ill. Jul. 11, 2016) (noting that "transgender prisoner[s] with feminine characteristics in male prison[s]" are "more likely to be victimized").

Second, Plaintiff must show that Defendants acted with "deliberate indifference to that risk, which requires a subjective inquiry into [their] state of mind." *Tay*, 457 F. Supp. 3d at 684. "[O]fficial[s] must both be aware of facts from which the inference could be drawn that a substantial risk or serious harm exists, and [they] must also draw the inference." *Farmer*, 511 U.S. at 837. Such awareness may be demonstrated "by showing that [a prisoner] complained to prison officials about a specific threat to h[er] safety," *McGill v. Duckworth*, 944 F.2d 344, 349 (7th Cir. 1991), which Plaintiff has repeatedly done. *See* Iglesias Decl. at ¶¶ 24−43, 54−59. Defendants

"disregard[ed] that risk by failing to take reasonable measures to abate it." *Farmer*, 511 U.S. at 847; *see Tay*, 457 F. Supp. 3d at 684−86 (finding that the subjective component of a failure-to-protect claim was met in part by proof that defendants "kn[e]w that Plaintiff is a transgender woman and is therefore particularly vulnerable in a men's facility"); *Hampton*, 2018 WL 5830730, at *13 (finding that the subjective component of a failure-to-protect claim was met by defendants' knowledge of a transgender woman's lawsuits, grievances, and PREA filings documenting her sexual and physical abuse in men's prisons).

Federal courts consistently recognize that the subjective prong of a failure-to-protect claim may be satisfied when prison officials know that a transgender woman is in a men's prison. *See Doe v. District of Columbia*, 215 F. Supp. 3d 62, 77 (D.D.C. 2016) ("[A] jury could infer that [prison officials] knew Doe faced a substantial risk of rape . . . as a transgender woman."); *Stover v. Corr. Corp. of Am.*, No. 1:12-cv-00393-EJL, 2015 WL 874288, at *9 (D. Idaho Feb. 27, 2015); *Lojan v. Crumbsie*, No. 12-CV-0320 (LAP), 2013 WL 411356, at *4 (S.D.N.Y. Feb. 1, 2013); *see also Zollicoffer v. Livingston*, 169 F. Supp. 3d 687, 691 (S.D. Tex. 2016) (noting that the "vulnerability of transgender prisoners to sexual abuse is no secret"). Given Plaintiff's history of rape, sexual assault, and sexual harassment while housed in men's facilities, "keeping her there may be tantamount to confining her in a cell with a cobra," thus putting her at risk of serious harm. *Tay*, 457 F. Supp. 3d at 685; *see Brown*, 398 F.3d at 911.

II. Plaintiff Has No Adequate Remedy at Law.

Plaintiff has no adequate remedy at law. As this Court has recognized in another case involving a transgender woman held in men's prisons, "money will not make [the woman] whole or protect her from physical and emotional abuse." *Tay*, 457 F. Supp. 3d at 687−88; *see Flower Cab Co. v. Petitte*, 685 F.2d 192, 195 (7th Cir. 1982) (noting that "quantification of injury is

difficult and damages are . . . not an adequate remedy" in cases "involv[ing] prison conditions"). The harms Plaintiff faces as a woman housed in a men's facility who is denied the necessary medical care she needs cannot be addressed by monetary damages. There is no adequate remedy for "preventable life-long diminished well-being and life-functioning" when a transgender person is denied the ability to socially transition, and "any award would be seriously deficient as compared to the harm suffered." *Whitaker ex rel. Whitaker*, 858 F.3d at 1046 (internal quotes omitted). Indeed, Plaintiff's complaint does not even seek money damages, only declaratory and injunctive relief.

III. Plaintiff Will Continue to Suffer Irreparable Harm Absent Injunctive Relief.

Plaintiff's suffering shows that she "will likely suffer irreparable harm" absent injunctive relief. *Id.* at 1044. The ongoing deprivation of Plaintiff's constitutional rights is an irreparable harm. *See Preston v. Thompson*, 589 F.2d 300, 303 n.3 (7th Cir. 1978) (noting in a prison case that "[t]he existence of a continuing constitutional violation constitutes proof of an irreparable harm"); *Tay*, 457 F. Supp. 3d at 687 ("The ongoing deprivation of Plaintiff's Eighth and Fourteenth Amendment [equal-protection] rights . . . is an irreparable harm sufficient to warrant a preliminary injunction.").

Without relief from this Court, Plaintiff will "suffer irreparable harm in the interim," *Hampton*, 2018 WL 5830730, at *9, that "cannot be prevented or fully rectified" by a final judgment. *Whitaker ex rel. Whitaker*, 858 F.3d at 1045 (internal quotation marks omitted). Plaintiff's physical and mental health remain at risk given her inadequate medical care and her exposure to violence from which BOP staff do not protect her. *See Tay*, 457 F. Supp. 3d at 687 (finding irreparable harm where a transgender woman in a men's facility was "assaulted, harassed, and threatened"); *Monroe*, 424 F. Supp. 3d at 545 (finding irreparable harm caused by "lack of

proper treatment for gender dysphoria"); *Hampton*, 2018 WL 5830730, at *15 (finding irreparable harm where a transgender woman in a men's facility was assaulted and staff did not protect her).

IV. The Balance of Harms and the Public Interest Require Injunctive Relief for Plaintiff.

If Plaintiff makes the tripartite threshold showing, the Court next considers "the irreparable harm the moving party will endure if the preliminary injunction is wrongfully denied versus the irreparable harm to the nonmoving party if it is wrongfully granted" and "the effects, if any, that the grant or denial of the preliminary injunction would have on nonparties (the 'public interest')." *Turnell v. CentiMark Corp.*, 796 F.3d 656, 662 (7th Cir. 2015). In this analysis, the Court "weighs the balance of potential harms on a 'sliding scale,'" such that "the more likely [the movant] is to win, the less the balance of harms must weigh in h[er] favor" to warrant injunctive relief. *Id*.

Here, the balance of party harms weighs strongly in favor of injunctive relief for Plaintiff. Because Defendants continue to deny her adequate medical care, unlawfully house her in a men's facility, and fail to protect her from the constant risk of violence, Plaintiff remains at a significant ongoing risk of harm. If this Court denies her relief, Plaintiff will continue to endure the mental and physical harms of mistreated gender dysphoria, sexual harassment, physical assault, and sexual assault in addition to the harms of continuing constitutional violations.

In contrast, granting injunctive relief would visit only minimal costs on Defendant. Prisoners in BOP custody are routinely transferred between facilities; Plaintiff herself has been transferred within the past four months. Iglesias Decl. at ¶ 44. Moreover, if providing Plaintiff adequate treatment for her gender dysphoria and protecting her from threats of violence constitute costs to Defendants, Defendants *already* owe such duties of treatment and protection. *See Farmer*, 511 U.S. at 833−34 (noting that prison officials "have a duty . . . to protect prisoners from violence

at the hands of other prisoners" and that "[b]eing violently assaulted in prison is simply not part of the penalty that criminal offenders pay" (internal quotation marks omitted)).

The public interest is also served by granting Plaintiff injunctive relief. Indeed, "the public has the 'highest' interest in preventing the violation of a party's constitutional rights." *Monroe*, 424 F. Supp. 3d at 546 (quoting *United States v. Raines*, 362 U.S. 17, 27 (1960)). In the prison context, remedying a "continuing constitutional violation . . . certainly would serve the public interest." *Preston*, 589 F.2d at 303 n.3; *see Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009). Specifically, "it is in the public interest to ensure that Plaintiff's constitutional rights are not violated by correctional officers." *Tay*, 457 F. Supp. 3d at 689; *see Hoskins v. Dilday*, No. 16-CR-334-MJR-SCW, 2017 WL 951410, at *7 (S.D. Ill. Mar. 10, 2017) ("[T]he public interest is best served by ensuring that corrections officers obey the law.").

Federal courts generally do not interfere with prison administrative matters except when, as here, constitutional concerns require such intervention. *See Williams v. Lane*, 851 F.2d 867, 871 (7th Cir. 1988) (noting that federal courts will intervene in prison administration "to remedy unjustified violations of those rights retained by prisoners"). Here, the public interest weighs heavily in favor of an injunction to protect Plaintiff's constitutional rights. *See Tay*, 457 F. Supp. 3d at 679 (noting that "courts usually hesitate to interfere" with inter-prison transfers unless "an inmate's constitutional rights are at issue"); *Hampton*, 2018 WL 5830730, at *16 (same).

V. Plaintiff's Requested Relief Complies with the PLRA.

Pursuant to the PLRA, Plaintiff has exhausted all available administrative remedies to challenge Defendants' unconstitutional conduct, including filing complaints with BOP's Northeast Regional Office and the Department of Justice, filing PREA complaints, and complaining to prison officials. Iglesias Decl. at ¶¶ 13−21, 23−35, 54−59; 42 U.S.C. § 1997e(a). These remedies have

been unsuccessful. *See Dole v. Chandler*, 438 F.3d 804, 813 (7th Cir. 2006) (finding exhaustion when a prisoner "took all steps necessary to exhaust one line of administrative review, and did not receive instructions on how to proceed once his attempts at review were foiled"); *Lewis v. Washington*, 300 F.3d 829, 833 (7th Cir. 2002) (holding that administrative remedies are exhausted "when prison officials fail to respond to inmate grievances"); *Walker v. Sheahan*, 526 F.3d 973, 979 (7th Cir. 2000) (finding exhaustion when a prisoner "submit[ted] a grievance but received no ruling").

Here, Plaintiff has waited and received no meaningful response to her emergency grievances that sufficiently "asserted [Defendants'] shortcomings in the form of denying her adequate and appropriate . . . health treatment and placing her in a men's prison despite being a female." *Hampton*, 2018 WL 5830730, at *9. This lack of response—in addition to Defendants' ongoing lack of response to years of complaints about the mistreatment of Plaintiff and her gender dysphoria—is sufficient to demonstrate exhaustion under the PLRA. *See Godfrey v. Harrington*, 13-cv-0280-NJR-DGW, 2015 WL 1228829, at *7 (S.D. Ill. Mar. 16, 2015) (noting that, in emergency situations, waiting sixteen days with no response to a grievance "may be sufficient to exhaust, particularly when the inmate is in imminent danger of harm").

CONCLUSION

For the foregoing reasons, the Court should enter a preliminary injunction enjoining Defendants to (i) provide Plaintiff with the medically necessary healthcare she needs, including permanent hair removal and gender confirmation surgery; (ii) house Plaintiff at an institution consistent with her gender identity; and (iii) protect Plaintiff from the known and serious risks of harm she continues to face while housed in a men's prison.

Dated: April 6, 2021

Respectfully submitted,

/*s*/ John A. Knight

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

CRISTINA NICHOLE IGLESIAS
(a.k.a. CRISTIAN NOEL IGLESIAS),

Plaintiff,

v.

IAN CONNORS, *et al.*,

Defendants.

Case No. 19-cv-00415-RJN

Judge Nancy J. Rosenstengel

DECLARATION OF DR. RANDI ETTNER, Ph.D., IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Randi Ettner, hereby state:

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I am the immediate past Secretary and served as a member for more than twelve years of the Board of Directors of the World Professional Association of Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have extensive experience treating transgender individuals with gender dysphoria in my clinical practice and have published numerous books and articles on the topic.

2. I have been retained by counsel for Plaintiff Cristina Iglesias to provide the Court with my expert evaluation and opinion regarding the appropriateness of the treatment for gender dysphoria provided by the Defendants. This declaration provides my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on the health and well-being of individuals living with gender dysphoria; (ii) information regarding best practices and the generally accepted standards of care for individuals with gender dysphoria; and (iii) the

results of my review of Plaintiff's treatment for gender dysphoria. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

I. QUALIFICATIONS AND BASIS OF DECLARATION

3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am 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.

4. During the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1977 to present.

5. 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* (co-editors Monstrey & Eyler; Rutledge 2007); and the 2nd edition (co-editors Monstrey & Coleman; Routledge, 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, am on the editorial boards of *Transgender Health* and the *International Journal of Transgender Health*, and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,500 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Incarcerated Persons and provide training to medical professionals on healthcare for transgender inmates.

7. I have lectured throughout North America, Europe, South America, and Asia on topics related to gender dysphoria and have given grand rounds on gender dysphoria at university 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 U.S. Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and gender dysphoria in Illinois.

8. I have been a consultant to news media and have been interviewed as an expert on gender dysphoria for hundreds of television, radio, and print articles throughout the country.

9. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with gender dysphoria in prison settings. I was deposed as an expert in the following cases over the past four years: *Claire, et al. v. Fla. Dep't of Management Serv., et al.*, Case No. 4:20-cv-00020 (2020); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW (D. Idaho 2018); *Monroe v. Jeffreys*, No. 18-156-NJR (S.D. Ill. 2018); *Faiella v. Am. Med. Response*, No. HHD CV-15-6061263 (Conn. Super. Ct. 2015); *Broussard v. First Tower Loan*, No. 2:15-CV-011-61 (D. La. 2016); *Carrillo v. U.S. Dep't of Justice Exec. Office of Immigr. Rev.* (2017); *Jane Doe v. Clenchy, et al.*, No. CV-09-201 (Me. Super. Ct. 2011); *Kothmann v. Rosario*, No. 13-CV-28-OC22 (D. Fla. 2013); *Gore v. Lee*, No. 3:19-cv-00328 (M.D. Tenn. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH

(W.D. Pa. 2020); *Eller v. Prince George's Cty. Pub. Schs.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Ray v. Himes*, No. 2:18-cv- 00272-MHW-CMV (S.D. Ohio).

10. A true and correct copy of my Curriculum Vitae, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as Appendix A.

11. My clinical consulting fee in this case is 375 USD per hour. My retention agreement in this case is attached hereto as Appendix C.

II. MATERIALS CONSIDERED

12. 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 three 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.

13. In preparing this declaration, I also reviewed and relied on the following: Plaintiff's medical and mental health records that have been provided to me by counsel; records related to Plaintiff's Federal Bureau of Prisons ("BOP") grievances; Plaintiffs' First Amended Complaint; Declaration in Support of Plaintiff's Motion for Preliminary Injunction; and BOP policies and procedures related to transgender prisoners and gender dysphoria treatment.

14. Lastly, I conducted and have relied on a very brief phone interview of Plaintiff.

III. GENDER DYSPHORIA

15. 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 particular gender, such as male or female.

16. At birth, infants are typically classified as male or female. This classification becomes the person's birth-assigned gender. Typically, persons born with the external physical characteristics of males psychologically identify as men, and those with the external physical characteristics of females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned gender, giving rise to a sense of being "wrongly embodied."

17. For some, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in gender dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one's assigned gender.

18. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

19. In 2013, with the publication of DSM-5, the Gender Identity Disorder ("GID") diagnosis was removed and replaced with gender dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge

that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity disordered. Rather, the diagnosis is based on the distress or dysphoria that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis connoted "that the patient is 'disordered.'" American Psychiatric Association ("APA"), Gender Dysphoria (2013). But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition." *Id.* By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013).

20. In addition, the categorization of gender dysphoria and its placement in the DSM system is different for gender dysphoria than it was for GID. In every version of the DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, gender dysphoria is classified on its own. And as recently as June 16, 2018, the World Health Organization ("WHO") likewise reclassified the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because the new classification removes gender incongruence form the chapter on mental and behavioral disorders, recognizing that it is not a mental illness.

21. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two ofthe following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, theanticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (orin young adolescents, a desire to prevent the development of the anticipated sexcharacteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the othergender.
4. A strong desire to be of the other gender (or some alternative gender differentfrom one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative genderdifferent from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

22. In addition to renaming and reclassifying gender dysphoria, the medical research that supports the gender dysphoria diagnosis has evolved. Unlike DSM's treatment of GID, the DSM-5 includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria").

23. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that gender dysphoria has a physiological and

biological etiology. 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.*, 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 (2011); 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); Luders et al., *Gender effects on cortical thickness and the influence of scaling*, 2 J. Behav. & Brain Sci. 357, 360 (2006); Krujiver et al*., Male-to- female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034–41 (2000). Interestingly, differences between transgender and non-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.

24. In addition, scientific investigation has found a co-occurrence of gender dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. Gomez- Gil et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265–69 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of gender dysphoria. *See* Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int'l J. Transgenderism 24 (2013) (abstract: "[t]he responses of our twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their

genetics than their rearing."); *see also* Green, *Family co-occurrence of "gender dysphoria": ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499–507 (2000).

25. 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:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetalbrain, 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 brainduring early development. There is no evidence that one's postnatal socialenvironment plays a crucial role in gender identity or sexual orientation.

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

IV. TREATMENT OF GENDER DYSPHORIA

A. WPATH Standards of Care

26. Gender dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of gender dysphoria are set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (7th version, 2011). The WPATH promulgated Standards of Care ("SOC") 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, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the SOC. *See, e.g.*, American Medical Association (2008) Resolution 122 (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).

27. As part of the SOC, many transgender individuals with gender dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of gender dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalizedtransphobia; enhancing social and peer support improving body image; orpromoting resilience.

SOC at 9–10.

28. The treatment of incarcerated persons with gender dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the SOC for people in correctional settings. *See* NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), http://www.ncchc.org/transgender-transsexual-and gender-nonconforming health-care).

29. Under the SOC, while it is true that "[r]easonable accommodations to the institutional environment can be made in the delivery of care consistent with the [Standards of Care]." SOC at 68. "Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations." *Id.*

30. Once a diagnosis of gender dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

31. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with gender dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. *See* Section VII. In particular, the SOC provide that all mental health professionals should have certain minimum credentials before treating patients with gender dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the

DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and continuing education in the assessment and treatment of gender dysphoria. SOC at 22.

32. Importantly, the SOC require that "[m]ental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria." SOC at 22–23. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of gender dysphoria, or the mentorship and supervision of an expert in this field.

33. 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.

34. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care, or place patients at significant risk.

35. While psychotherapy or counseling can provide support and help with the personal and social aspects of a gender transition, they are not a substitute for medical intervention where medical intervention is needed, nor are they preconditions for such intervention. By analogy, in Type One diabetes, counseling might provide psychoeducation about living with a chronic condition, and information about nutrition, but it does not obviate the need for insulin.

36. For many individuals with gender dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called "social transition," are an important part of treatment for the condition. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. *See, e.g.*, Greenberg & Laurence 1981; Ettner 1999; Devor 2004.

B. Hormone Therapy

37. For almost all individuals with persistent, well-documented gender dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. The Standards of Care specify that "feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender non-conforming individuals with gender dysphoria." SOC at Section VIII, p. 33.

38. Hormone therapy is a well-established and effective means of treating gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all agree that hormone therapy in accordance with the WPATH Standards of Care is medically necessary treatment for many individuals with gender dysphoria. *See* American Medical Association (2008), Resolution 122 (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).

39. The goals of hormone therapy for individuals with gender dysphoria are: (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth; and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e., non-transgender males born with insufficient testosterone or non-transgender females born with insufficient estrogen). *See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

40. The therapeutic effects of hormone therapy are twofold: (i) with endocrine treatment, the patient acquires congruent sex characteristics, i.e., for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (ii) hormones act directly on the brain, via receptors sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of a sense of well-being. *See, e.g.*, Cohen-Kettenis & Gooren 1993. Hormone therapy induces desired physical changes for transgender men as well, such as a deepened voice, growth in facial and body hair, cessation of menses, and atrophy of breast tissue, among other changes. SOC at 36.

41. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormones and compared them with a group of transgender individuals who did not. Untreated individuals showed much higher levels of depression, anxiety, and social distress than those who received hormone therapy. *See* Rametti, et al. 2011; *see also* Colizzi et al. 2014; Gorin-Lazard et al. 2014; Gorin-Lazard et al. 2011.

42. Some individuals with gender dysphoria experience profound relief from hormone therapy alone such that further treatment, such as surgical intervention, is not required. *See* SOC at 8–9.

43. While the WPATH Standards indicate that significant mental health concerns must be reasonably well-controlled prior to initiation of hormone therapy, co-occurring mental health conditions should only be a reason to delay therapy in the most exceptional circumstances. For example, a physician might not initiate hormone therapy in a patient who is actively psychotic or so delusional as to be unable to consent to the treatment plan. Otherwise, it is extremely common for gender dysphoric patients to present with co-existing mental health issues and past trauma, which usually are a result of their underlying gender dysphoria. There is no legitimate medical basis for denying treatment simply because a patient also has been diagnosed with, for example, clinically significant anxiety, depression, or PTSD.

C. Gender-Affirming Surgery

44. For some individuals with severe gender dysphoria, hormone therapy alone is insufficient. Relief from their dysphoria cannot be achieved without surgical intervention to modify primary sex characteristics, i.e., genital reconstruction. Under the contemporary understanding of gender identity, transition-related medical treatments confirm, not "change," an individual's sex by aligning primary and secondary sex characteristics with a person's gender identity. The WPATH Standards state:

> While many transsexual, transgender, and gender- nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria . . . . For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.

SOC at 54–55.

45. Genital reconstruction surgery for transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the uro-genital structures appearing and functioning as is typical for non-transgender women. Both are critical in alleviating or eliminating gender dysphoria. Other forms of gender-affirming surgeries, such as bilateral mastectomy for transgender men, allow the individual to attain body congruence with respect to secondary sex characteristics.

46. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many people, it is the only effective treatment. *See, e.g.*, Pfäfflin & Junge 1998; Smith et al. 2005; Jarolím et al. 2009.

47. WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all support surgery in accordance with the SOC as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) ("For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role."); 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" and referencing studies demonstrating the effectiveness of gender-affirming surgeries).

48. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect." *See* Monstrey et al. 2007. More than three decades of research confirms that gender-affirming surgery is therapeutic and therefore an effective treatment for gender dysphoria.

49. In a 1998 meta-analysis, Pfäfflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded that "reassignment procedures were effective in relieving Gender Dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes." Pfäfflin & Junge 1998.

50. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after gender-affirming surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" Smith et al. 2005. Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, Gender Dysphoria, had decreased to such a degree that it had disappeared." *Id.*

51. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the 18 outcome studies of the last two decades, the conclusion that [gender-affirming surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare."

52. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for gender dysphoria. For example, a 2001 study published in

Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases" Landen 2001. Similarly, urologists at the University Hospital in Prague, Czech Republic, in a Journal of Sexual Medicine article concluded, "Surgical conversion of the genitalia is a safe and important phase of the treatment of male-to-female transsexuals." Jarolím 2009.

53. Patient satisfaction is an important measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender-affirming surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009); and greater acceptance and integration into the family (Lobato et al. 2006).

54. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships. *See, e.g.*, Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al. 2009; Klein & Gorzalka 2009; Jarolím et al. 2009; Smith et al. 2005; Rehman et al. 1999; De Cuypere et al. 2005).

55. Multiple long-term studies have confirmed these results. *See, e.g.*, "Transsexualism in Serbia: a twenty-year follow-up study" (Vujovic et al. 2009); "Long-term assessment of the physical, mental, and sexual health among transsexual women" (Weyers et al. 2009); "Treatment follow-up of transsexual patients" (Hepp et al. 2002); "A five-year follow-up study of Swedish adults with gender identity disorder" (Johansson et al. 2010); "A report from a single institute's 14

year experience in treatment of male-to-female transsexuals" (Imbimbo et al. 2009); "Follow up of sex reassignment surgery in transsexuals: a Brazilian cohort" (Lobato et al. 2006).

56. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that surgery is a medically necessary, not experimental, treatment for severe gender dysphoria as demonstrated by its inclusion as a medically necessary treatment in the SOC.

57. In 2008, WPATH issued a "Medical Necessity Statement" expressly stating: "These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient."

58. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

59. On September 25, 2013, the Department of Health Care Services of the State of California Health and Human Services Agency issues All Plan Letter 13-011, which makes clear that gender confirmation surgery was a covered service for Medi-Cal beneficiaries when the surgery was not cosmetic in nature and referred providers to the WPATH Standards of Care for the "criteria for the medical necessity of transgender services." Illinois recently joined the states that will provide gender confirmation surgery for Medicaid recipients. *See, e.g.*, Lisa Schencker, *Illinois Medicaid to cover gender reassignment surgery*, Chi. Trib. (Apr. 5, 2019 at 4:40 AM), https://www.chicagotribune.com/business/ct-biz-medicaid-gender-reassignment-surgery-20190405-story.html.

60. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that a Medicare regulation denying coverage of "all transsexual surgery as a treatment for transsexualism" was not valid under the "reasonableness standard." The Board specifically concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases." The corpus of studies increases yearly as access to gender confirmation surgery increases. For example, a group at Cornell University conducted a review of 56 studies from 1991 to June 2017 on the outcomes of gender confirming surgeries for transgender individuals. The results verify the efficacy of surgery: 52 studies (93%) reported beneficial effects, 4 studies reported mixed or null effects, and no studies demonstrated that gender confirming surgeries cause harm. What We Know: The Public Policy Research Portal, What does the scholarly research say about transition on transgender well-being?, Cornell University; 2019), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people//.

D. Living Consistently with Gender Identity

61. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender dysphoria, like many medical conditions, often requires more than a single intervention for effective treatment. For example, clothing and grooming that affirm one's gender identity, such as bras for transgender females, and the use of congruent pronouns are critically important components of treatment protocols. *See* Greenberg & Laurence 1981; Ettner 1999; Devor 2004.

62. The SOC also specifically provide that permanent body hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating gender dysphoria

for transgender women. Other gender-appropriate grooming items for transgender women such as feminine deodorant, moisturizer, hair care, and make-up may also be necessary for treatment. Similarly, male grooming items are important components of social role transition for transgender men. These accoutrements are critical to the mental well-being and social transition of gender dysphoric people.

63. The most commonly pursued gender confirming medical intervention in transgender women is hair removal. Facial hair is an obvious source of distress in those who are transitioning. Electrolysis and/or laser hair removal are typically required to live safely and comfortably in the affirmed female gender. The removal of hair is an ongoing process for most transgender women, particularly those with dark and coarse hair, and requires numerous treatments. A very recent study explored satisfaction with hair removal in relation to gender dysphoria and psychological symptoms in a group of 281 transgender women. Bradford, Rider & Spencer, 2019. Results found satisfaction with hair removal correlated with less body dysphoria, less depression and anxiety, and an overall enhanced sense of wellbeing. The authors conclude that "[t]hese findings cast significant doubt on the assertion that hair removal services for transfeminine people are cosmetic" *Id.*

64. "Mis-gendering"—the act or referring to a transgender person by the incorrect gender—is harmful to the mental health of transgender persons. It threatens their identity and exacerbates the mental health problems attendant to gender dysphoria. It is therefore important, especially for those charged with the medical treatment and mental health care of transgender persons with gender dysphoria, to refer to transgender people using the correct, gender-affirming names and pronouns. *See* Bauer et al. 2015; Frost et al. 2015; Bockting 2014.

65. Gender dysphoric prisoners are at heightened risk. In addition to the concerns outlined above, it is important for correctional facilities to consider appropriate housing and shower/bathroom facilities for transgender individuals. Each individual's gender identity and role, dignity, and personal safety should be taken into account in housing and other assignments. *See* SOC at 68. If the institution fails to do so, there can be serious consequences for mental and physical health. *See* Seelman, 2016.

66. Moreover, transgender women with feminine characteristics are at elevated risk for harm when housed in male prisons. Verbal harassment, physical abuse, sexual assault, and sexual coercion occur at an alarming rate, and too often there is inadequate protection.

67. Clothing and grooming items are particularly important to provide to transgender patients with gender dysphoria who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender women, 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 for gender dysphoric women.

68. Transgender individuals in the correctional environment sometimes are disciplined for attempts at grooming that effectively amount to self-treatment of their gender dysphoria. For example, transgender women may be disciplined for tattooing makeup, for wearing a ponytail, or modifying their clothing to match their gender identity.

69. Social role transition—including, for example, transgender women appearing feminine—has an enormous impact in the treatment of gender dysphoria. An early seminal study

emphasized the importance of aligning presentation and identity and its benefits to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were presenting in their birth-assigned sex role. Greenberg & Laurence 1981. In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one's gender identity. More recently, Sevelius (2013) proposed a "gender affirmation model" which demonstrated that access to gender affirming components of social role transition equated with better mental health, fewer suicide attempts, and lower levels of depression and posttraumatic stress disorder (PTSD) symptoms.

E. Risks of Providing Inadequate Care

70. Without adequate treatment, adults with gender dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social, or other areas of life. Many gender dysphoric women without access to appropriate care 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 & McDuffie 2009. A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

71. Gender dysphoria intensifies with age. As cortisol rises with normal aging, the ratio of DHEA to cortisol is affected, which acts to alter brain chemistry and intensify gender dysphoria. With the passage of time, inmates who require surgical treatment will experience greater distress, and no means of relief. *See* Ettner 2013; Ettner & Wiley 2013. This is particularly deleterious for transgender inmates serving long sentences.

72. Because gender dysphoria entails clinically significant and persistent feeling of stress and discomfort with one's assigned gender, if it is not treated, those feelings of stress and discomfort will increase and may become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without treatment, these individuals may not be capable of accomplishing simple everyday tasks, and may become increasingly socially withdrawn and isolated, which only serves to further exacerbate their symptoms.

73. Gender dysphoria left untreated or inadequately treated, will result in serious physical harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. *See* SOC at 67. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. *See, e.g.*, Bauer 2015.

74. Moreover, gender dysphoric individuals have a profound discomfort with their genitalia. Without effective treatment as outlined above, this often leads to attempts at auto-castration, which can result in lasting physical trauma or even death in more serious cases. *See* Brown & McDuffie 2009.

75. In sum, the results of providing inadequate treatment are predictable and dire, and take one of three paths: profound psychological decompensation, surgical self-treatment, or suicide.

V. CONCERNS REGARDING THE ADEQUACY OF PLAINTIFF'S TREATMENT FOR GENDER DYSPHORIA BY THE DEFENDANTS

76. Based on the small amount of information I have been able to receive about Plaintiff's treatment, I reached some tentative conclusions regarding the adequacy of the treatment provided to Plaintiff by Defendants as well as instances where the treatment deviated from the accepted standards set forth in the SOC. To do so, I reviewed a handful of Plaintiff's medical records kept by the BOP and spoke for approximately 30 minutes with the Plaintiff by phone. I also received her First Amended Complaint and reviewed her Declaration in Support of Plaintiff's Motion for Preliminary Injunction. In order to properly analyze the treatment that Plaintiff is receiving, I would need to be able to see a more complete set of her medical and mental health records and an opportunity to conduct a longer interview of her. It would also be helpful if I could conduct psychological testing of her.

77. Plaintiff is a 46-year-old transgender woman currently incarcerated and in the custody of the BOP at Federal Correctional Institution Fort Dix ("Fort Dix"), a men's prison. Plaintiff has identified as a female since a very young age. At the age of 12, Plaintiff told her mother that she wanted to have gender confirmation surgery in order to live as a female. She acted in a very feminine manner and was subjected to emotional and physical abuse by her father. Plaintiff withdrew from school in tenth grade and began to socially transition, living her life as a woman. She started to wear her hair in a traditionally feminine hairstyle, wear female clothes, and use birth control to develop breasts.

78. Plaintiff entered BOP custody in 1994. Soon thereafter, in or around 1994, she was diagnosed with GID by Dr. Brian Gray, a BOP psychologist who treated her. In 2015, Dr. Lewis, BOP's Chief Psychologist, changed Ms. Iglesias's diagnosis from GID to gender dysphoria to reflect the updated diagnosis in the DSM-5, published in 2013. Medical records for Ms. Iglesias

indicate that in 2009, she attempted auto-penectomy. Attempts to remove the genitals are not uncommon in prison settings, but only occur when the gender dysphoria is inadequately or inappropriately treated. *See* Brown, 2010. Auto-castration and auto-penectomy are not considered genital mutilation or evidence of psychosis. Rather, they are referred to as surgical-self-treatment ("SST"). These life-threatening behaviors occur when severe gender dysphoria is undertreated. For Ms. Iglesias, the anatomical dysphoria regarding her genitalia is severe. She describes her genitals as a "tumor or cancer that needs to be removed," feels "dirty and disgusted" when viewing or touching her genitals, and relates that it is hard to control the impulse to auto-penectomize.

79. On March 23, 2021, I spoke with Plaintiff by phone for approximately one-half hour. Ms. Iglesias related that her gender dysphoria was intensifying, which is typical at middle age, and tearfully described the extreme distress she is now experiencing. She related "feeling as though her existence is torture." She has been traumatized by the numerous attacks she has endured and the indifference to her safety. She is permitted to shave only once a week, which leaves her feeling like a "bearded lady," i.e., a freak of nature. She described experiencing symptomatology consistent with posttraumatic stress disorder: sadness, fear, hopelessness, nightmares, panic attacks, and disordered eating.

80. I have serious concerns about Plaintiff's treatment for gender dysphoria. It appears to fall far outside of what is recommended by the SOC in that BOP personnel have been aware of Plaintiff's gender dysphoria diagnosis since 1994 but delayed providing her with hormone therapy for more than twenty years until 2015. And for five years, it appears that they have ignored her serious medical needs for surgery and transfer to a female facility. She has also been denied permanent hair removal for several years.

81. In addition, Plaintiff has been housed in male prisons for many years despite the fact that she has identified and lived only as a woman for many years, even prior to her incarceration. A note in her medical records on December 18, 2019 states that she has developed female physical characteristics: "breast development, body fat changes, more feminine, skin is better" as a result of hormone therapy. After years of endocrine treatment, Ms. Iglesias has been hormonally confirmed. In other words, she has the female secondary sex characteristics and circulating sex steroids corresponding to adult females. She has been subjected to extensive sexual abuse, physical abuse, and harassment and misgendering by BOP staff and male prisoners during her time in BOP custody in male facilities.

82. Public spaces and facilities—such as restrooms, locker rooms, and correctional facilities—are designed to segregate men and women. Prison settings where transgender people are confined and lack agency can be particularly devastating and even deadly.

83. While it is impossible for me to reach any definitive conclusions based on the small amount of information I have received, I have grave concerns regarding Ms. Iglesias. She reports being extorted for money and forced to engage in coercive sexual acts. She is experiencing psychological symptoms consistent with complex posttraumatic stress disorder (PTSD), which is chronic and intractable. Her feelings of hopelessness are clinically concerning, given that hopelessness is a reliable predictor of suicide, more so even than depression. Her status as a transgender woman is being weaponized against her. Other prisoners torment and victimize her, and prison officials are indifferent to her medical needs and safety.

VI. CONCLUSION

84. It is my experience that when transgender women are placed in a facility with men and subjected to abuse, they inevitably develop 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 hyperarousal. Thus, the trauma of PTSD has biological and psychological sequelae.

85. It is my opinion that Ms. Iglesias requires transfer to a female facility where she will be free from violent sexual assault and able to live consistent with her affirmed gender. Having evaluated several other transgender women to determine their eligibility for transfer to female facilities, I am not aware of any reason Ms. Iglesias could not be safely placed in a female correctional facility. The SOC confirm that placement of individuals 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 to minimize the risk of attacks. SOC Section XIV. It is my understanding that, consistent with this guidance, the BOP and state corrections departments have begun housing transgender women in female facilities, on a case-by-case basis, in consideration of their safety.

86. It is also my opinion that Ms. Iglesias should be provided gender confirmation surgery. She successfully consolidated her female identity long ago. She has relentlessly advocated for medical and surgical care. Despite years of feminizing hormone therapy, she continues to suffer from gender dysphoria. The long-term hormonal treatment she has undergone has served to intensify her anatomical dysphoria. Having a female appearance and male genitalia generates

profound distress. Her inability to reduce or modulate this internal anguish is likely to result in emotional decompensation and/or self-harm.

87. Ms. Iglesias has met and exceeded the five enumerated criteria for gender confirmation surgery as stated in the WPATH SOC: (1) she has persistent, well-documented gender dysphoria; (2) she is free of any disorders of thought and able to provide informed consent; (3) she is over the age of majority; (4) she has no medical or mental health issues that contraindicate surgery. On the contrary, surgery is the therapeutic intervention that would significantly improve her emotional and physical health; (5) she has lived in her affirmed and well-consolidated female gender.

88. I have read Defendant Connor's statement that "gender-affirming surgery is considered after real life experience in your preferred gender." However, this is not accurate. The "real life experience" criterion was abandoned twelve years ago. The SOC do not require patients to have "real life experiences," only to live in the congruent gender role for twelve months. Ms. Iglesias has done so for decades. The SOC do not focus on the location where the patient lived in the role but on the patient's experience of living in the role, regardless of the patient's surroundings.

89. It is my opinion that owing to the severity of her gender dysphoria, the ensuing clinically significant distress, and the limited efficacy of hormone therapy, gender confirmation surgery is medically necessary for Ms. Iglesias.

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

Dated: April 5, 2021

Dr. Randi Ettner PhD

Dr. Randi Ettner, Ph.D.

APPENDIX A

RANDI ETTNER, PHD
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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

Psychonueroimmunology 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

PUBLICATIONS

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Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin*, 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

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 *Distinguished Sex and Gender Revolutionary* 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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APPENDIX C

ROGER BALDWIN FOUNDATION
OF ACLU, INC.
Illinois

ROGER BALDWIN FOUNDATION OF
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WWW.ACLU-IL.ORG

March 17, 2021

Dr. Randi Ettner
1214 Lake Street
Evanston, IL 60201
rettner@aol.com

Dear Dr. Ettner:

As you know, the American Civil Liberties Union Foundation ("ACLUF"), the Roger Baldwin Foundation of ACLU, Inc. ("RBF"), Feirich Mager Green Ryan ("FMGR") and Winston & Strawn LLP ("W&S") represent the plaintiff Cristina Iglesias in *Iglesias v. Connors* in connection with the adequacy of her medical care and protection from harm provided by the Federal Bureau of Prisons. Acting on behalf of the plaintiff, we have discussed with you the possibility of your serving in this matter as a testifying expert. Thank you for agreeing to serve as an expert witness in this case. The terms of your retention are set forth below. Please signify your agreement to these terms by countersigning this letter and returning it to me.

This letter confirms that the ACLUF, RBF, FMGR and W&S have retained you as an expert in this case and we have agreed to pay your pro bono rate of $375 per hour, up to a maximum of $3000 per day. The same rate applies to report writing, phone conferences, face-to-face meetings and travel time. You will charge us the rate of $425 per hour for trial and deposition testimony. In addition to professional fees, we will compensate you for reasonable direct out-of-pocket expenses, such as charges for travel. You will inform us if you anticipate that your total fees will exceed $10,000 prior to incurring those costs in excess of that amount, and inform us of the same for every additional $10,000 thereafter prior to incurring those costs in excess of that amount.

You should send your bills directly to my attention at the Roger Baldwin Foundation of ACLU, Inc., and bills should be issued no less frequently than every other month. You have advised us that no conflicts exist with your taking on this assignment. You agree that you will not provide expert witness services in this case or matters directly connected with this case for any person or entity, other than the plaintiffs and their attorneys, without the advance written approval of the plaintiffs' attorneys. In addition, you agree that while this matter is still active you will not provide expert services for any person or entity who has asserted or proposes to assert any position antagonistic to that of the plaintiffs in this case, without the advance written approval of the plaintiffs' attorneys.

In the course of your retention, we may call upon you to provide information, prepare studies or reports, participate in meetings, review materials, and undertake other tasks for ACLUF, RBF, FMGR and W&S as counsel to Ms. Iglesias. We intend that your work, opinions,

conclusions and communications will be covered by the attorney-client privilege and attorney work product rule to the extent provided by law, and you agree to do all things necessary to preserve those privileges.

You agree that documents and information of any kind that you (or anyone assisting you) acquire will be maintained in strict confidence and not disclosed to any other person or party without our prior written consent. All documentary material provided to you (or to anyone assisting you) together with all copies thereof must be returned immediately upon request. In addition, any activities that you perform under this agreement and any conclusions or judgments that you reach or have reached must be maintained as confidential in the same way. You should understand that these restrictions will continue even after the termination of your consulting work for us and after the termination of the matter.

Reports and other documents generated, or obtained by you, in the course of your work on this matter will be the property of the ACLUF, RBF, FMGR and W&S. If authored by you, the work will be considered "Works Made For Hire" and all right, title and interest in such works is hereby assigned by you to the ACLUF, RBF, FMGR and W&S.

The nature and duration of your retention will be determined by the ACLUF, RBF, FMGR and W&S and may be modified or terminated by us at any time for any reason. This agreement may not be amended or modified, nor any provision waived by any means other than an express writing to such effect which is signed by you and the ACLUF, RBF, FMGR and W&S.

* * *

We greatly appreciate your help in this matter, and we are looking forward to working with you.

Sincerely yours,

The Roger Baldwin Foundation of ACLU, Inc.

By: _____

Name: John A. Knight

Agreed and accepted this ___ day of _____, 2021.

Dr. Randi Ettner

By: Dr. Randi Ettner

Agreed and accepted this 18 day of March, 2021.

The American Civil Liberties Union Foundation

By: _____
Name: James D. Esseks

Agreed and accepted this 18 day of March, 2021.

Feirich Mager Green Ryan

By: _____
Name: _____

Agreed and accepted this ___ day of _____, 2021.

Winston & Strawn

By: _____
Name: Kevin Warner

Agreed and accepted this 18 day of March, 2021.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

CRISTINA NICHOLE IGLESIAS
(a.k.a. CRISTIAN NOEL IGLESIAS),

Plaintiff,

v.

IAN CONNORS, *et al.*,

Defendants.

Case No. 19-cv-00415-RJN

Judge Nancy J. Rosenstengel

DECLARATION OF CRISTINA NICHOLE IGLESIAS
IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

I, Cristina Nichole Iglesias, am the Plaintiff in the above captioned case. I have personal knowledge of this information set forth herein and if called upon to testify, I would testify to the truth of the following:

1. I am a 46-year-old woman in the custody of the Federal Bureau of Prisons ("BOP") at Fort Dix in Fort Dix, New Jersey. Fort Dix is a men's prison.

2. I am a transgender woman and have identified as female for most of my life even though I was assigned male at birth.

3. Since a very young age, I have known that I am female. At the age of 12, I asked my mother for gender-confirmation surgery ("GCS") because of my need to live as a girl in a body that fully reflected who I am. I acted in a very feminine manner and consequently was subjected to emotional and physical abuse at the hands of my father during this time.

4. I left school after the tenth grade. I began socially transitioning by wearing my hair in a female hairstyle and wearing female clothes, and I took birth control medication so I could develop breasts.

5. My social transition helped me and other people see me as the woman I am, but it was not enough.

6. I entered the BOP in 1994. Since then, I have always been held in men's prisons. I have been held in men's prisons because I was assigned male at birth, even though I shared with BOP that I identify as female.

7. Soon after I entered BOP custody, I was diagnosed with gender identity disorder in or around 1994 by Dr. Brian Gray, a BOP psychologist who treated me. In 2015, my diagnosis was changed to gender dysphoria in accordance with updated medical terminology.

8. I first requested hormone therapy from BOP medical staff in 2011 but was initially denied treatment. It was not until 2015, four years later, that medical staff finally approved my request to begin hormone therapy. I experienced several changes in my body as a result of hormone therapy, such as developing breasts.

9. In addition to hormone therapy, I have done everything I can to live completely as the woman I know myself to be while in prison. I wear a bra, women's underwear, and use makeup and grooming items when they are available to me. However, I am still held in men's prisons and some prison staff refer to me by male pronouns.

10. Despite hormones, female clothing, and grooming items, I continue to suffer from extreme mental and physical anguish because of my gender dysphoria.

11. Throughout the years I have been in BOP custody, I have dealt with devastating symptoms from the condition, including severe depression, anxiety, stress, and thoughts of self-treatment through castration. In 2009, my gender dysphoria was so bad that I attempted to remove my testicles and penis. My gender dysphoria continues to intensify and worsen as time goes on and I grow older, causing me even more distress.

12. I have also been placed on suicide watch many times by BOP staff because of my need for treatment. I continue to suffer from suicidal thoughts due to my need for permanent hair removal and GCS.

My Requests for Surgery.

13. Beginning in 2016, I started requesting GCS informally and formally to treat the gender dysphoria I am still suffering from.

14. I made these requests to BOP staff members, Dr. Randall Pass, the clinical team at United States Penitentiary at Marion ("USP-Marion"), and Defendant Hollingsworth, USP-Marion's current warden.

15. Dr. Pass is the clinical director at USP-Marion, and he confirmed that I met the WPATH criteria for GCS and should receive it.

16. On January 6, 2018, I appealed Defendant Hollingsworth's and the Regional Director's denials of my request for GCS to the Central Office Administrative Remedies Division. I explained that the delay was causing me further emotional and psychological distress, depression, anxiety, stress, and thoughts of self-mutilation.

17. On March 2, 2018, Defendant Connors, a national inmate appeals administrator at the BOP, responded and acknowledged that BOP's Transgender Clinical Care Team ("TCCT"), which is overseen by the Transgender Executive Council ("TEC"), had received my request for GCS. Defendant Connors said that he was going to defer to the TCCT to make a decision.

18. In November 2019, I was transferred from USP-Marion to Federal Medical Center-Lexington ("FMC-Lexington"). I was told by staff at USP-Marion that I was being transferred there to receive GCS. After I arrived there, I was told that there were no surgeons in Kentucky who performed the GCS I needed.

19. On December 3, 2019, I filed an appeal to the Central Office Administrative Remedies Division. In my appeal I again requested GCS and all treatments necessary to prepare me for it as called for by the WPATH standards.

20. On December 18, 2019, I had a consultation with a nurse practitioner named Tammy C. Thomas at the Endocrinology Department at the University of Kentucky HealthCare. BOP set the consultation up to evaluate me for GCS. Ms. Thomas evaluated me and found that I met the WPATH standards for GCS and she recommended that I have it.

21. On March 13, 2019, I received a response to my December 3, 2019 appeal to the COARD. Defendant Connors issued the BOP's decision and said that I could not have GCS because I did not meet the requirements to be transferred to a female facility and because my hormone levels "have not been maximized or stabilized."

My Request for Permanent Hair Removal.

22. I also need permanent body and facial hair removal for the treatment of my gender dysphoria.

23. Defendant Hollingsworth and BOP's Regional Director denied my request for permanent hair removal. I appealed on March 7, 2018. On April 6, 2018, Defendant Connors denied my appeal on the grounds that I had not reported any major emotional or environmental problems during my last visit with Psychological Services. The denial was also based on the provider not indicating that I needed it.

My Requests for Transfer to a Female Facility.

24. As part of treatment for my gender dysphoria and for my safety, I have also repeatedly requested to be transferred to a women's facility. Those requests have been denied and I have appealed them.

25. On November 21, 2016, I requested transfer to a women's facility by sending a request to Loretta Lynch, who was the United States Attorney General at the time. My request was forwarded to the warden at the Federal Correctional Complex in Butner, North Carolina.

26. On December 21, 2016, I received notification that my request was "under review as part of an ongoing process."

27. On May 31, 2017, I appealed the Regional Director's decision denying my request to be transferred to a women's facility. I explained that I needed the transfer for my gender dysphoria treatment and for my safety.

28. On July 6, 2017, Defendant Connors notified me that my request was denied, in part because it was repetitive of earlier appeals for transfer to a women's facility.

29. On March 13, 2020, I was again denied transfer to a women's facility by Defendant Connors. In the denial, he stated that "surgery is created after real world experience in your preferred gender."

30. On March 24, 2020, I applied for transfer to a women's facility at FMC-Lexington. I sent my request to the warden at FMC-Lexington.

31. Because I am a transgender woman, I am a target for physical and sexual violence in a male facility. That is a second crucial reason why I need to be transferred to a women's facility.

32. Being housed in male prisons has put my health and life in danger. I have been subjected to extensive sexual abuse, physical abuse, and harassment by BOP staff and other prisoners.

33. As I have described, I have made numerous requests to BOP staff to be transferred to a women's facility to avoid further harm.

34. I have reported numerous instances of sexual abuse, including rape, physical abuse, and/or harassment. Prior to my transfer to Fort Dix, I reported instances in 2001, 2013, 2015, 2016, 2017, 2019, and 2020.

35. I have made numerous requests to be placed in protective custody to avoid these harms but I am still harassed by other prisoners and prison staff, even in protective custody.

36. While I have been in BOP custody, other prisoners have frequently exposed themselves to me, groped me, watched and attempted to watch me when I shower, and demeaned me in other ways, including asking to see my breasts.

37. I have suffered numerous sexual assaults in BOP custody because I am a transgender woman in men's prisons.

38. In November 2019, I was raped by another prisoner. I reported the rape to BOP medical personnel.

39. In January 2020, I was held hostage by a cellmate because he did not want to be housed with a transgender woman. He would not release me until the prison entered the cell and used force to get him out before he was able to harm me.

40. From my experience, because I am a woman with female physical characteristics, such as breasts, I am a target for rape and forced prostitution in men's prisons.

41. In January 2020, I refused to allow a male prisoner to prostitute me. He put a hit on me and offered $500.00 to another prisoner for the opportunity to be in a cell with me to hurt me. BOP staff at FMC-Lexington entered a separation order between him and me. We remained in the same facility.

42. BOP staff have also harassed me. One staff member threatened to house me with a convicted sex offender if I did not stop making complaints about needing medical care and requesting a transfer to a women's facility.

43. Throughout my time in BOP custody, I have constantly been misgendered by both prison staff and other prisoners, which causes and worsens my gender dysphoria, depression, anxiety, stress, and thoughts of self-harm.

My Experience at Fort Dix

44. I was transferred to Fort Dix on December 14, 2020 because of the violence and threats of further violence I experienced at FMC-Lexington. However, my experience at Fort Dix has been even worse than what I experienced at FMC-Lexington.

45. I was initially housed in Unit 5703 where I stayed for approximately two months in quarantine because I became infected with coronavirus disease 2019 ("COVID-19") after my transfer to Fort Dix.

46. After recovering from COVID-19 in around mid-February 2021, I was moved to Unit 5702. Unit 5702 is a general population unit with two-person bunk beds, twelve prisoners per room, on three open floors, which are open to one another through stairways. The entire unit has a capacity of at least 300 people. Since being moved to Unit 5702, I have been subjected to sexual violence and extortion because I am a transgender woman.

47. Two male prisoners began demanding sex and money from me and threatened me with violence if I did not do what they said. The person who originally used threats to demand sex and money is Osvaldo Rosa, who goes by the name "Danny." I do not know the actual name of the other prisoner who used violence to demand sex and money from me, but his last name is "Mejia." Both Danny and Mejia are leaders in the Ñetas gang.

48. Danny approached me in or about March 3, 2021 or March 4, 2021 and said that I would have to pay him $10,000.00 if I wanted to survive at Fort Dix. He threatened me with a knife if I did not stay with him near his bunk bed and shadowed me everywhere I went in the unit. He also started making me phone my relatives and friends to ask them for money if they wanted to avoid being harmed.

49. Many of the prisoners at Fort Dix have cell phones, even though they are contraband. Prisoners are able to communicate with one another and with people outside of the prison. Danny collected the money I was being forced to send him through a mobile application known as "Cash App," through four different user handles.

50. I have paid Danny approximately $8,000.00 to date to save myself from physical violence and additional acts of sexual violence. I received the money from my family, a friend outside of prison, a fellow prisoner at Fort Dix named Ryan Jaselkis ("Ry"), and the government stimulus payments resulting from COVID-19. Ry is also a transgender woman.

51. Danny forced me to give him oral sex four different times during February and March 2021. The last time he held me at knifepoint. Danny frequently pulled knives on me to remind me that my life is at risk. Danny hid the knives from the corrections officers in a space in the ceiling near the light bulbs.

52. During the first week of March 2021, Mejia raped me, forcing me to engage in anal sex. He told me that was punishment for not giving him money.

53. On one occasion in February 2021, Danny and Mejia forced me to show my breasts to two other members of the Ñetas who go by the nicknames "Flacko" and "J.R."

54. I did not file a grievance immediately because I was afraid of retaliation from Danny, Mejia, other prisoners at Fort Dix, and Fort Dix staff, even in protective custody. My fear

was exacerbated because Fort Dix is an open facility, which increases my exposure to possible violence from other prisoners. Eventually, however, I had no other choice. On March 3, 2021, I filed a grievance with the BOP Regional Office about the extortion and sexual violence I had been experiencing. I have heard of nothing being done as result of that grievance.

55. On or about March 4, 2021, Danny warned me that if I did not produce the rest of the money owed to him, $2000.00, then my life was in danger. This is when I decided that I had to make additional complaints about my treatment.

56. On March 4, 2021, I filed a complaint online through the United States Department of Justice Sexual Abuse Reporting System. That system is accessible through the prisoner computer system. The complaint is supposed to go directly to the Department of Justice Office of the Inspector General. I forwarded that complaint to the Fort Dix warden as well as my unit manager. I requested protective custody on March 4, but Lt. Morales, a unit supervisor, refused to provide that until March 5, 2021.

57. Later in the day on March 4, 2021, both Ry and I filed two PREA Complaints against Danny and Mejia. In the complaints we detailed the extortion, physical and sexual abuse, and reported the contraband cell phone and knives that Danny was using.

58. After Ry and I filed the PREA complaints, we were summoned to Lt. Morales's office. I explained to Lt. Morales what was happening to me, including being raped and threatened at knifepoint. Lt. Morales held me and Ry in his office for approximately eight hours. During that time, medical staff met with me and gave me HIV prevention medication.

59. After approximately eight hours in Lt. Morales's office, I was moved in the early morning of March 5, 2021 to Unit 5751, a three-story unit in which each prisoner is in a cell accessible to all others through the stairwells. I was still fearful for my life because male prisoners

could reach me whenever they wished and there were other members of the Ñetas there. Danny could communicate with them via the contraband cell phones. I stayed in my cell as much as possible and tried my best to avoid contact with other prisoners in the unit.

60. I was placed on the first floor of Unit 5751—which is reserved for persons with disabilities—but was told by a counselor that I could not stay much longer because I do not have a disability. The counselor me that I would have to return to Unit 5702.

61. On the morning of March 5, 2021, I also spoke with Lt. Atkinson from Special Investigation Services. He did not seem to care about the physical and sexual violence I had experienced. Instead, he wanted more information about the role of my counselor, A. Milletta (sp.), in the spread of illegal cell phones and drugs at Fort Dix. I also informed Lt. Atkinson where the knives and phones were being hidden.

62. I was so afraid to return to the unit with the prisoners who had demanded sex and extorted money from me that I again requested to be moved to protective custody. I did so even though I know from past experience how psychologically and emotionally devastating the experience of being held in protective custody would likely be for me. On March 5, 2021, I was moved to protected custody where I remain today.

63. In addition to the isolation of protective custody, the circumstances there have significantly increased my symptoms from gender dysphoria. The only female commissary items that I am allowed are a bra and panties and I am only allowed to shave once a week, leaving me with facial hair that is deeply disturbing for me.

64. Soon after I was placed in protective custody, Danny was also moved there. Fortunately, he was in a separate cell. However, he threatened me from his cell and tried to

intimidate me by telling the other prisoners in protective custody that I was a snitch and giving them contact information for my friends and family.

65. On March 17, 2021, Danny was released to a half-way house pre-release program.

66. Even though Danny has been released, I continue to be fearful of being released back to general population where Mejia, other members of the Ñetas, and other male prisoners will be able to target me for violence because I am transgender woman and labeled as a snitch.

67. For about five years I have struggled to get the surgical treatment I need for gender dysphoria and transfer to a female facility. My hopefulness when I learned that I was being transferred from USP-Marion to FMC-Lexington to receive GCS was soon taken away when I learned that surgery was unavailable there. BOP's choice to transfer me to Fort Dix – rather than a female facility—has left me even more hopeless. I am the most distraught I have ever been from what I have endured these past few months.

68. I have requested medication for the anxiety, stress, and depression I am experiencing from being denied the gender dysphoria treatment I need and my constant fear for my life. I suffer from panic attacks, sleeplessness, and loss of appetite. I am once again facing a difficult struggle each day to keep from harming myself or ending my life entirely.

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

Dated: April 1, 2021

/s/ Cristina Nichole Iglesias
Cristina Nichole Iglesias[1]

[1] Plaintiffs' counsel spoke with Ms. Iglesias on April 1, 2021 by telephone. During this conversation Ms. Iglesias authorized Plaintiffs' counsel to file this declaration on her behalf. Plaintiffs' counsel will supplement this declaration with a signed copy from Ms. Iglesias once it is returned to them by U.S. Mail from Ms. Iglesias.