

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

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Exhibit 6

The Honorable Robert J. Bryan

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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA**

C. P., by and through his parents, Patricia
Pritchard and Nolle Pritchard; and PATRICIA
PRITCHARD,

Plaintiffs,

v.

No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

EXPERT REPORT OF RANDI C. ETTNER, PH.D.

I, Randi C. Ettner, Ph.D., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a licensed clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I received my doctorate in psychology from

1 Northwestern University in 1979. I was the chief psychologist at the Chicago Gender Center
2 from 2005 to 2016, when it moved to the Weiss Memorial Hospital. Since that time, I have been
3 a consultant to the Center for Gender Confirmation Surgery at Weiss Memorial Hospital and a
4 member of the Medical Staff. The center specializes in the treatment of individuals with gender
5 dysphoria. I have been involved in the treatment of patients with gender dysphoria since 1977,
6 when I was an intern at Cook County Hospital in Chicago.

7
8 4. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of
9 Psychological Specialties, and a Fellow and Diplomate in Trauma/Posttraumatic Stress Disorder
10 (PTSD).

11 5. During the course of my career, I have evaluated and/or treated over 3,000
12 individuals with gender dysphoria and mental health issues related to gender variance.

13 6. I have published four books related to the treatment of individuals with gender
14 dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery*
15 (Ettner, Monstrey & Eyler, 2007) and the second edition (Ettner, Monstrey & Coleman, 2016). I
16 also have authored numerous articles in peer-reviewed journals regarding the provision of care to
17 this population. I serve as a member of the editorial boards for the *International Journal of*
18 *Transgenderism and Transgender Health*.

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20 7. I am the immediate past Secretary of the World Professional Association for
21 Transgender Health (“WPATH”) (formerly the Harry Benjamin Gender Dysphoria Association),
22 as well as a member of the Board of Directors for 12 years. I am an author of the *WPATH*
23 *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming*
24 *People* (7th version), published in 2011. The WPATH promulgated *Standards of Care*
25 (“*Standards of Care*”) are the internationally recognized guidelines for the treatment of persons
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1 with gender dysphoria and serve to inform medical treatment in the United States and throughout
2 the world.

3 8. I have lectured throughout North America, South America, Europe, and Asia on
4 topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on
5 gender dysphoria at medical hospitals.

6 9. I am the honoree of the externally-funded *Randi and Fred Ettner Fellowship in*
7 *Transgender Health* at the University of Minnesota. I have been an invited guest at the National
8 Institute of Health to participate in developing a strategic research plan to advance the health of
9 sexual and gender minorities, and in November 2017 was invited to address the Director of the
10 Office of Civil Rights of the United States Department of Health and Human Services regarding
11 the medical treatment of gender dysphoria. I received a commendation from the United States
12 House of Representatives on February 5, 2019 recognizing my work for WPATH and on the
13 treatment of gender dysphoria in Illinois.

14 10. I have treated hundreds of PTSD patients who experience the long-term
15 psychological effects of trauma. As a forensic psychologist, I have been retained as an expert and
16 testified in numerous cases about the harm that befalls victims of criminal victimization, natural
17 catastrophes, and exposure to extremely stressful events.

18 11. I have been retained as an expert regarding gender dysphoria and its treatment in
19 multiple court cases in both state and federal courts, as well as administrative proceedings, and
20 have repeatedly qualified as an expert. I have also been a consultant to policy makers regarding
21 appropriate care for transgender inmates and for the Centers for Medicare and Medicaid in the
22 state of Illinois. I have also served as a consultant to multiple school districts in the state of
23 Wisconsin as well as the Chicago public school system on issues related to gender identity.
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1 12. The information provided regarding my professional background, experiences,
2 publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my
3 most up-to-date curriculum vitae is attached as **Exhibit A**.

4 **B. Compensation**

5 13. I am being compensated for my work on this matter at a rate of \$375.00 per hour
6 for preparation of declarations and expert reports. I will be compensated \$500.00 per hour for any
7 pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will
8 receive a flat fee of \$2,500.00 for any travel time to attend deposition or trial, and will be
9 reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing
10 expert testimony in this matter. My compensation does not depend on the outcome of this
11 litigation, the opinions I express, or the testimony I may provide.

12 **C. Previous Testimony**

13 14. Over the past four years, I have given expert testimony at trial or by deposition
14 in the following cases: *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. 2021); *Iglesias v.*
15 *Connor*, No. 19-cv-0415-RJN (S.D. Ill. 2021); *Monroe v. Jeffreys*, No. 18-15-156-NJR (S.D. Ill.
16 2021); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D.
17 Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire*
18 *v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v.*
19 *Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328
20 (M.D. Tenn. 2020); *Eller v. Prince George's Cnty. Public Sch.*, No. 8:18-cv-03649-TDC (D.
21 Md. 2020); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Ray v. Acton*,
22 No. 2:18-cv-00272 (S.D. Ohio 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019);
23 *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW (D. Idaho 2018).
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1 **II. BASES FOR OPINIONS**

2 15. In preparing this report, I have relied on my training and years of research and
3 clinical experience, as set out in my curriculum vitae, and on the materials listed therein. A true
4 and accurate copy of my curriculum vitae is attached hereto as **Exhibit A**. It documents my
5 education, training, research, and years of experience in this field and includes a list of my
6 publications.

7 16. I have also reviewed the materials listed in the bibliography attached hereto as
8 **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed publications. I
9 generally rely on these materials when I provide expert testimony, and they include the documents
10 specifically cited as supportive examples in particular sections of this report.

11 17. I also rely upon my interviews of C.P. and his parents on March 19, 2022, and
12 C.P.’s mental health and medical records.

13 18. Additionally, I have reviewed the Amended Class Action Complaint (ECF No. 38)
14 and the court’s Order Denying Defendant’s Motion to Dismiss (ECF No. 23) in this case.

15 19. The materials I have relied upon in preparing this report are the same types of
16 materials that experts in my field of study regularly rely upon when forming opinions on the
17 subject. I reserve the right to revise and supplement the opinions expressed in this report or the
18 bases for them if any new information becomes available in the future, including as a result of new
19 scientific research or publications or in response to statements and issues that may arise in my area
20 of expertise.
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III. EXPERT OPINIONS

A. Sex and Gender Identity

20. At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person’s actual sex. However, for transgender people, the sex assigned at birth does not align with the individual’s genuine, experienced sex, resulting in the clinical distress that characterizes the condition of gender dysphoria.

21. Research has identified that determination of sex is far more complex than what is seen as part of a genital exam. Instead, a number of factors go into the determination of a person’s sex. Among the factors that comprise a person’s sex are their chromosomal composition (detectable through karyotyping); gonads and internal reproductive organs (detectable by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); fetal hormones (production of sex hormones by the fetus or exogenous exposure of sex hormones to the developing fetus); pubertal hormones (the change in hormonal milieu that results in the development of secondary sexual characteristics, such as facial hair and deep voice for those assigned male at birth, or breasts and menstrual cycles for those assigned female at birth); sexual differentiations in brain development and structure (detectable by functional magnetic resonance imaging studies and autopsy); and gender identity.

22. Gender identity is a person’s inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity and is a well-established concept in science and medicine. Every person has a gender identity. Like non-transgender people (also known as cisgender people), transgender people do not simply have a “preference” to act or behave consistently with each one’s gender identity.

1 23. The only difference between transgender people and cisgender people is that the
2 latter have gender identities that are consistent with their birth-assigned sex whereas the former
3 do not. A transgender man cannot simply turn off his gender identity like a switch, any more than
4 anyone else could.

5 24. In other words, transgender men are men and transgender women are women.

6 25. A growing assemblage of research documents that gender identity is immutable
7 and biologically based. Efforts to change an individual’s gender identity are therefore both futile
8 and unethical.

9 26. The evidence demonstrating that gender identity cannot be altered, either for
10 transgender or for non-transgender individuals, further underscores the innate and immutable
11 nature of gender identity. Past attempts to “cure” transgender individuals by means of
12 psychotherapy, aversion treatments or electroshock therapy, in order to change their gender
13 identity to match their birth-assigned sex, have proven ineffective and caused extreme
14 psychological damage. All major associations of medical and mental health providers, such as
15 the American Medical Association, the American Psychiatric Association, the American
16 Psychological Association, and WPATH’s *Standards of Care*, consider such efforts unethical.

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19 **B. Gender Dysphoria and Its Treatment**

20 27. Gender dysphoria is the clinically significant distress or impairment of functioning
21 that can result from the incongruence between a person’s gender identity and the sex assigned to
22 them at birth. Gender dysphoria is a serious medical condition associated with severe and
23 unremitting distress that results from the incongruity between various aspects of one’s sex. It is
24 codified in the *International Classification of Diseases* (11th revision: World Health
25 Organization), the diagnostic and coding compendia for mental health and medical professionals,
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1 and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental*
2 *Disorders*, Fifth Edition (DSM-5). People diagnosed with gender dysphoria have an intense and
3 persistent discomfort with their assigned sex.

4 28. In 1980, the American Psychiatric Association introduced the diagnostic term
5 gender identity disorder (GID) in the third edition of the Diagnostic and Statistical Manual of
6 Mental Disorders (DSM-III). The diagnosis of GID was maintained in a revised version of DSM,
7 known as DSM-III-R (1987), as well as in the DSM-IV, which was issued in 1994. The gender
8 identity disorder diagnosis presupposed that a person's identity was disordered, and was therefore
9 a permanent condition.
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11 29. In 2013, the American Psychiatric Association removed the GID diagnosis and
12 replaced it with a fundamentally different diagnosis, gender dysphoria. The change was not merely
13 a name change but was based on the evolving scientific understanding that gender incongruence
14 is not a mental illness, but rather a serious, treatable medical condition that creates significant
15 distress. This new diagnostic term, gender dysphoria, is an acknowledgment that gender
16 incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity
17 disordered. Rather, the diagnosis is based on the distress or dysphoria that some transgender people
18 experience as a result of the incongruence between the sex assigned at birth and gender identity,
19 and the social problems that ensue. The critical element of the gender dysphoria diagnosis is the
20 presence of symptoms that meet the threshold of clinical impairment. The American Psychiatric
21 Association changed the name and diagnostic criteria to be "more descriptive than the previous
22 DSM-IV term gender identity disorder and focus[] on dysphoria as the clinical problem, not
23 identity per se." DSM-5 at 451.
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1 30. “Gender Dysphoria” is the name of the diagnosis, and “gender dysphoria” is also
2 the psychiatric term for the severe and unremitting distress that the condition gives rise to.

3 31. The diagnostic criteria for gender dysphoria in Adolescents and Adults are as
4 follows:

5 a. A marked incongruence between one’s experienced/expressed gender and assigned
6 gender, of at least six months’ duration, as manifested by at least two of the
7 following:

8 i. A marked incongruence between one’s experienced/expressed gender and
9 primary and/or secondary sex characteristics (or in young adolescents, the
10 anticipated secondary sex characteristics).

11 ii. A strong desire to be rid of one’s primary and/or secondary sex
12 characteristics because of a marked incongruence with one’s
13 experienced/expressed gender (or in young adolescents, a desire to prevent
14 the development of the anticipated sex characteristics).

15 iii. A strong desire for the primary and/or secondary sex characteristics of the
16 other gender.

17 iv. A strong desire to be of the other gender (or some alternative gender
18 different from one’s assigned gender).

19 v. A strong desire to be treated as the other gender (or some alternative gender
20 different from one’s assigned gender).

21 vi. A strong conviction that one has the typical feelings and reactions of the
22 other gender (or some alternative gender different from one’s assigned
23 gender).
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1 b. The condition is associated with clinically significant distress or impairment in
2 social, occupational or other important areas of functioning.

3 32. Once a diagnosis of gender dysphoria is established, individualized treatment
4 should be initiated. Without treatment, individuals with gender dysphoria experience anxiety,
5 depression, suicidality, and other attendant mental health issues and are often unable to adequately
6 function in occupational, social, or other areas of life.

7 33. The medically accepted standards of care for treatment of gender dysphoria are set
8 forth in the *WPATH Standards of Care* (7th version, 2011), first published in 1979. The WPATH-
9 promulgated *Standards of Care* are the internationally recognized guidelines for the treatment of
10 persons with gender dysphoria and inform medical treatment throughout the world.

11 34. The American Medical Association, the Endocrine Society, the American
12 Psychological Association, the American Psychiatric Association, the World Health Organization,
13 the American Academy of Family Physicians, the National Commission of Correctional Health
14 Care, the American Public Health Association, the National Association of Social Workers, the
15 American College of Obstetrics and Gynecology, the American Society of Plastic Surgeons, and
16 The American Society of Gender Surgeons all endorse protocols in accordance with the WPATH
17 standards. (See, e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al.,
18 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); ACOG,
19 2021; NCCHC, 2009).

20 35. The *Standards of Care* identify the following treatment protocols for treating
21 individuals with gender dysphoria, which should be tailored to the patient's individual medical
22 needs:
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- a. Changes in gender expression and role, also known as social transition (which involves living in the gender role consistent with one’s gender identity);
- b. For transgender youth, treatment options include pubertal suppression therapy.
- c. Hormone therapy to feminize or masculinize the body in order to reduce the distress caused by the discordance between one’s gender identity and sex assigned at birth;
- d. Surgery to change primary and/or secondary sex characteristics; and
- e. 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 internalized transphobia; enhancing social and peer support; improving body image; and promoting resilience.

36. The ability to live in a manner consistent with one’s gender identity is critical to a person’s health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each transgender person takes to transition are not identical.

37. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. In other words, whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

38. **Psychotherapy:** Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for

1 medical intervention when medical interventions are required, nor is it a precondition for medically
2 indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing
3 psychoeducation about living with chronic illness and nutritional information, but counseling does
4 not obviate the need for insulin.

5 39. **Puberty Blockers: Puberty** Puberty blocking medication, which involves the
6 administration of gonadotrophin-releasing hormone analogues (GnRH), comprises methods of
7 temporarily suppressing endogenous puberty to alleviate gender dysphoria and give the patient
8 more time to work with their mental health and medical providers to assess treatment needs. These
9 blockers are reversible medications and once stopped, a patient immediately returns to the stage
10 of pubertal development that had begun when the treatment was initiated.

11
12 40. Puberty suppression also has the benefit of potentially rendering obsolete some
13 gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial
14 feminization, and vocal cord alteration, which otherwise would be required to correct the initial
15 “incorrect” puberty.

16
17 41. Puberty suppression has been used safely for decades in children with other
18 medical conditions. (de Vries, et al., 2014). Both the Endocrine Society and the WPATH’s
19 Standards of Care recommend initiation of puberty suppression at the earliest stages of puberty
20 (usually, Tanner 2), in order to avoid the stress and trauma associated with developing secondary
21 sex characteristics of the natal sex.

22 42. **Hormone Therapy:** For individuals with persistent, well-documented gender
23 dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress
24 of the condition. Cross sex hormone administration is a well-established and effective treatment
25 modality for gender dysphoria. The American Medical Association, the Endocrine Society, the
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1 American Psychiatric Association, and the American Psychological Association all concur that
2 hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically
3 necessary, evidence-based, best practice care for most patients with gender dysphoria.

4 43. The goals of hormone therapy are (1) to significantly reduce hormone production
5 associated with the person's birth sex, causing the unwanted secondary sex characteristics to
6 recede, and (2) to replace the natal, circulating sex hormones with either feminizing or
7 masculinizing hormones, using the principles of hormone replacement treatment developed for
8 hypogonadal patients (*i.e.*, those born with insufficient sex steroid hormones).

9 44. The therapeutic effects of hormone therapy are twofold. First, with endocrine
10 treatment, the patient acquires secondary sex characteristics congruent with their gender identity.
11 For transgender women, this means, *inter alia*, breast development, redistribution of body fat,
12 cessation of male pattern baldness, and reduction of body hair. For transgender men, this means,
13 *inter alia*, the voice deepens, growth of facial and body hair, redistribution of body fat, and overall
14 increase in muscle mass. Second, hormones act directly on the brain, via receptor sites, attenuating
15 the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.
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17 45. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone
18 therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention.
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20 46. For many transgender women patients, hormones alone will not provide sufficient
21 breast development to approximate the female torso. For these patients, breast augmentation has
22 a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus
23 unquestionable therapeutic results. Conversely, for many transgender men, hormones alone do
24 not reduce breast tissue and they therefore require surgical intervention, such as a mastectomy and
25 male chest contouring, to eliminate this most obvious typically female sex characteristic.
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1 47. For transgender women, genital confirmation surgery has two therapeutic
2 purposes. First, removal of the testicles eliminates the major source of testosterone in the body.
3 Second, the patient attains body congruence resulting from the normal appearing and functioning
4 female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender
5 dysphoria. Additionally, breast augmentation procedures play the critical role in treatment
6 mentioned in the paragraph immediately above.

7 48. For many transgender men, gender confirmation surgery in the form of a
8 hysterectomy—the removal of female reproductive organs, such as the uterus, ovaries, fallopian
9 tubes and cervix—is a medically necessary procedure for the treatment of gender dysphoria. A
10 hysterectomy confers three therapeutic benefits: First, it eliminates a source of estrogen and
11 preexisting conditions of tumors, cysts, fibroids or endometriosis. Second, it removes the increased
12 risk of ovarian cancer (thought to originate in the fallopian tubes) and other typically female
13 cancers associated with atrophied organs. Finally, a hysterectomy eliminates the need for routine
14 gynecological exams and significantly attenuates gender dysphoria.
15

16 **C. Gender-Affirming Medical and Surgical Treatment Are Safe and Effective.**

17 49. There is a large and growing body of evidence that demonstrates that the
18 provision of gender affirming medical and surgical treatment to treat gender dysphoria are both
19 safe and effective.
20

21 50. Peer-reviewed cross-sectional and longitudinal studies have found that the use of
22 puberty blockers is associated with a range of improved mental health outcomes for transgender
23 adolescents, including statistically significant improvements in internalizing psychopathology
24 (*e.g.*, anxiety and depression), externalizing psychopathology (*e.g.*, disruptive behaviors), global
25 functioning, and suicidality. (*e.g.*, Achilles, et al., 2020; Turban, et al., 2020; van der Miesen, et
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1 al., 2020; de Vries, et al., 2014; de Vries, et al., 2011). For example, a study by van der Miesen et
2 al., which compared 272 adolescents who had not yet received pubertal suppression with 178
3 adolescents who had been treated with pubertal suppression, found that those who had received
4 pubertal suppression had statistically significant lower “internalizing psychopathology” scores (a
5 measure of anxiety and depression). And de Vries et al.’s longitudinal study similarly found
6 statistically significant improvements in symptoms of depression and general functioning
7 following pubertal suppression for adolescents with gender dysphoria.

8
9 51. Decades of scientific research have validated the many benefits of hormonal
10 therapy for gender dysphoric patients. Peer-reviewed research studies have likewise found
11 improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen
12 or testosterone) for individuals with gender dysphoria, including adolescents. These include
13 statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and
14 depression), general well-being, and suicidality. (*e.g.*, Grannis, et al., 2021; Meyer, et al., 2020;
15 Achille, et al., 2020; Allen, et al., 2019; Heylens, et al., 2014; Colizzi, et al., 2014; Colizzi, et al.,
16 2013; Gomez-Gil, et al., 2012).

17
18 52. As early as 1980, researchers demonstrated that gender dysphoric patients living
19 without hormonal treatment showed greater psychopathology than patients who received
20 hormonal treatment; and greater adjustment was associated with longer periods of treatment
21 (Leavitt, et al.). Untreated patients exhibit much higher levels of depression, anxiety, and social
22 distress. (Rametti, et al., 2011; see also Colizzi, et al., 2014; Gorin-Lazard, et al., 2011.).
23 Hormonal treatment improves overall health in gender dysphoric patients and is associated with
24 a better quality of life (Gomez-Gil, et al., 2012; Colizzi, et al., 2013; Gorin-Lazard, et al., 2011).
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1 53. The American Medical Association, the Endocrine Society, the American
2 Psychiatric Association and the American Psychological Association also all agree that hormone
3 therapy is medically necessary treatment for many individuals with gender dysphoria. (See
4 Endocrine Society, 2017; American Medical Association, 2008; American Psychological
5 Association, 2015; American Psychiatric Association, 2012; American Psychiatric Association,
6 2009).

7 54. Decades of methodologically sound and rigorous scientific research have also
8 demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender
9 dysphoria and, indeed, for many, it is the only effective treatment. The American Medical
10 Association, the Endocrine Society, the American College of Obstetricians and Gynecologists, the
11 American Psychological Association, and the American Psychiatric Association all endorse
12 surgical therapy, in accordance with the *WPATH Standards of Care*, as medically necessary
13 treatment for individuals with severe gender dysphoria.
14

15 55. Surgeries are considered “effective” from a medical perspective, if they “have a
16 therapeutic effect” (Monstrey, et al., 2007). More than three decades of research confirms that
17 gender confirmation surgery is therapeutic and therefore an effective treatment for gender
18 dysphoria. (e.g., Almazan, et al., 2021; Murad, et al., 2010; Smith, et al., 2005; Pfafflin & Junge,
19 1998). Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is
20 the only effective treatment.
21

22 56. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from
23 12 countries, spanning 30 years. They concluded that “reassignment procedures were effective in
24 relieving gender dysphoria. There were few negative consequences and all aspects of the
25 reassignment process contributed to overwhelmingly positive outcomes” (Pfafflin & Junge, 1998).
26

1 57. Numerous subsequent studies confirm this conclusion. Researchers reporting on a
2 large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery
3 there was “a virtual absence of gender dysphoria” in the cohort and “results substantiate previous
4 conclusions that sex reassignment is effective” (Smith, et al., 2005). Indeed, the authors of the
5 study concluded that the surgery “appeared therapeutic and beneficial” across a wide spectrum of
6 factors and “[t]he main symptom for which the patients had requested treatment, gender dysphoria,
7 had decreased to such a degree that it had disappeared.” Similarly, a recent systematic review that
8 included data from 1,052 transmasculine patients who obtained chest surgery found that pooled
9 overall postoperative satisfaction was 92%. (Bustos, et al., 2021).
10

11 58. As a general matter, patient satisfaction is a relevant measure of effective treatment.
12 Achieving functional and normal physical appearance consistent with gender identity alleviates
13 the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have
14 shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender
15 confirmation surgery improves virtually every facet of a patient’s life. This includes satisfaction
16 with interpersonal relationships and improved social functioning (Rehman, et al., 1999; Johansson,
17 et al., 2010; Hepp, et al.; 2002; Ainsworth & Spiegel, 2010; Smith, et al., 2005); improvement in
18 self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith, et al.,
19 2005; Weyers, et al., 2009); and greater acceptance and integration into the family (Lobato, et al.,
20 2006).
21

22 59. Studies have also shown that surgery improves patients’ abilities to initiate and
23 maintain intimate relationships (Lobato, et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo,
24 et al., 2009; Klein & Gorzalka, 2009; Jarolim, et al., 2009; Smith, et al., 2005; Rehman, et al.,
25 1999; DeCuypere, et al., 2005).
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1 60. With regards to transgender adolescents, peer-reviewed research has also shown
2 improvements in mental health following gender-affirming chest surgery for transgender males
3 with gender dysphoria where medically indicated. (Mehringer, et al., 2021; Olson-Kennedy, et al.,
4 2018).

5 61. The research and studies supporting the medical necessity, safety, and
6 effectiveness of gender affirming medical and surgical care for the treatment of gender dysphoria
7 is the same type of evidence-based data that the medical community routinely relies upon when
8 treating other medical conditions.

9 62. Given the decades of extensive experience and research supporting the
10 effectiveness of gender affirming medical and surgical treatment, it is clear that this care is
11 medically necessary for the treatment of gender dysphoria, and not experimental or cosmetic.

12 63. Because of the overwhelming scientific evidence that gender affirming medical
13 care, including gender confirmation surgery, is medically necessary for the treatment of gender
14 dysphoria in some patients, many of the leading medical and professional organizations have
15 stated their opposition to exclusions of insurance coverage for that care, including the American
16 Medical Association, American Academy of Family Physicians, American College of
17 Obstetricians and Gynecologists, American Psychiatric Association, and WPATH. (*See* American
18 Medical Association and GLMA, 2019; WPATH, 2016; American Psychiatric Association, 2012;
19 American Academy of Family Physicians, 2012; American College of Obstetricians and
20 Gynecologists, 2011; American Medical Association, 2008; American Psychological Association,
21 2008.).

22 64. Finally, insuring transition-related care is affordable and cost-effective for a
23 number of reasons. First, only a small percentage of the population is transgender. While there are
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1 a range of estimates, most studies indicate that transgender people comprise less than 1 percent
2 (ranging from approximately 0.1 to 0.6 percent) of the United States population. Second, even
3 among this small population, not every person will require various surgical procedures because
4 individual medical needs vary, and some may be precluded from surgery based on age or other
5 health conditions. While absorbing the cost of this care can be challenging on an individual's
6 personal budget, researchers affiliated with the Johns Hopkins Bloomberg School of Public
7 Health, and the RAND Corporation, have demonstrated that the cost of insuring surgical care
8 through a group health plan is negligible at most. (Padula et al., 2015; RAND Corp., 2016).
9 Moreover, offering access to medically necessary transition-related care is far more cost-effective
10 than denying coverage and having to treat the resulting consequences, which can include
11 depression, anxiety, suicidality, and other conditions.
12

13 **D. Harms Resulting from the Denial of Care.**

14 65. The overarching goal of treatment for gender dysphoria is to eliminate clinically
15 significant distress by aligning an individual patient's body and presentation with their internal
16 sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-
17 identity formation is a fundamental undertaking for all human beings. Denial of medically
18 indicated care to transgender people signals that such people are "inferior" or "unworthy," and
19 triggers shame.
20

21 66. Denying gender affirming care not only frustrates those treatment goals but
22 exacerbates gender dysphoria and its associated depression and suicidality. Conversely, Bauer et
23 al. found a 62% reduction in risk of suicide ideation with the completion of medical transition.
24 That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year. Studies
25 have also shown that gender confirmation surgery has been linked with a reduction in
26

1 psychological distress and suicidal ideation for transgender patients (Almazan, et al., 2021).

2 Withholding this care results in serious negative health outcomes for transgender patients.

3 67. More broadly, the negative effects of discrimination impact transgender people
4 throughout their lives. A wealth of research establishes that transgender people suffer from
5 discrimination, stigma, and shame from those external forces. The “minority stress model”
6 explains that the negative impact of the stress attached to being stigmatized is socially based. The
7 stress process can be both external—i.e., actual experiences of rejection and discrimination
8 (enacted stigma)—and because of such experiences, internal—i.e., perceived rejection and the
9 expectation of being rejected or discriminated against (felt stigma). A 2015 survey of 28,000
10 transgender and gender nonconforming individuals found that 30% reported being fired,
11 discriminated against, or otherwise experiencing mistreatment in the workplace (James, et al.,
12 2016).

14 68. Experiencing discrimination, including in health care settings, has negative
15 impacts on patients’ mental health and well-being. A 2012 study of transgender adults found fear
16 of discrimination increased the risk of developing hypertension by 100%, owing to the
17 intersectionality of shame and cardiovascular reactivity. Another 2012 study of discrimination
18 and implications for health concluded that “living in states with discriminatory policies ... was
19 associated with a statistically significant increase in the number of psychiatric disorder
20 diagnoses.” And a 2019 study found that experiencing discrimination in health care settings posed
21 a unique risk factor for heightened suicidality among transgender individuals, a population
22 already at heightened risk compared with the general population (Herman, et al., 2019).

24 69. Until recently, it was not fully understood that these experiences of shame and
25 discrimination could have serious and enduring consequences. But it is now known that
26

1 marginalization, stigmatization, and victimization are some of the most powerful predictors of
2 current and future mental health problems, including the development of psychiatric disorders.
3 The social problems that young transgender people face actually create the blueprint for future
4 mental health, life satisfaction, and even physical health. A recent study of 245 gender
5 nonconforming adults found that stress and victimization during childhood and adolescence was
6 associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction,
7 anxiety, and suicidality in adulthood (Toomey, et al., 2010). A 2011 Institute of Medicine (IOM)
8 report concurs: “the marginalization of transgender people from society is having a devastating
9 effect on their physical and mental health.” And the American Journal of Public Health recently
10 reported that more than half of transgender women “struggle with depression from the stigma,
11 shame and isolation caused by how others treat them.”
12

13 70. While a growing body of research documents that structural forms of stigma
14 (namely, policies sanctioning discrimination) harm the health of transgender people, a 2010 study
15 was the first to show that structural stigma is associated with all-cause mortality (*i.e.*, deaths from
16 any cause). In other words, stigma—a chronic source of psychological stress—disrupts
17 physiological pathways, increasing disease vulnerability, and leading to premature death.
18

19 71. Adding to the corpus of research in this area is a relatively new approach to the
20 investigation of the relationship between discrimination and health. Neuroscientists have
21 discovered that, in addition to causing serious emotional difficulties and physical harms,
22 discrimination, harassment, and verbal abuse permanently alter the architecture of the brain.
23 Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause
24 cognitive difficulties in individuals who have been routinely subjected to humiliation and
25 ostracism (Nickel, 2018; Ohashi, et al., 2017; Teicher, et al., 2010).
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IV. ASSESSMENT OF PLAINTIFF C.P.

72. Section IV of this report is designated as CONFIDENTIAL pursuant to the Protective Order in this matter (ECF No. 25).

73. C.P. is a 17-year-old (DOB [REDACTED] 05) who resides in the state of Washington with his parents and two younger siblings. C.P. is a transgender male, having been assigned female at birth.

74. C.P. met all developmental milestones, and his childhood medical history is unremarkable save for a surgery at one year of age to correct Vesicoureteral reflux.

75. I interviewed C.P. remotely, via videoconferencing, on March 19, 2022. C.P. was alert, completely cooperative and maintained eye contact. He sat throughout the interview without fidgeting or restlessness. He engaged with ease, and attention and memory are within normal limits. Speech is normal and well-modulated. Thought processes are logical, goal directed and without distortion. Affect was appropriate to content, and there is no evidence of any mood disorders. Judgement and insight are age appropriate.

76. As a young child, C.P., like most transgender youngsters, felt “different” and confused about the suitability of the assigned sex. C.P. related that he enjoyed and excelled at sports and was most comfortable with male playmates. He consistently wore boys’ clothing and asked to be called by a “boy” name. By age 10, C.P.’s gender identity was so well-established and intractable that he was regarded as male by his peers. Even prior to learning that there is a name for his feelings of incongruity, C.P. essentially transitioned to his affirmed gender. At age 11, he attained a legal name change. Ultimately, when he learned of the condition of gender dysphoria, he experienced enormous relief: “It wasn’t something I was stuck with. I could do something about it.”

1 77. To that end, and with the support of parents and extended family, C.P. was able to
2 obtain the medically necessary care he required, thereby avoiding the negative sequelae of female
3 puberty and attendant menses and unwanted secondary sex characteristics. Dr. Kevin Hatfield
4 monitored C.P.'s pubertal progression, and initiated a GnRH agonist at stage Tanner 2 plus, via a
5 Vantas implant. In due course, intramuscular testosterone, the medically indicated treatment for
6 gender dysphoria, was initiated. This protocol is consistent with the recommendations of The
7 Endocrine Society, the American Medical Association, the American Academy of Pediatricians,
8 and WPATH.

9 78. Ultimately, the transmasculine individual requires chest reconstruction. Without
10 this surgery, it is virtually impossible for transgender males to live safely and comfortably. Having
11 female breasts in an otherwise male-appearing body, invokes shame, and can even provoke
12 violence. Without this intervention, transgender males have no alternative except to bind the
13 breasts. Chest binding (compressing breast tissue to give the appearance of a flat chest) is almost
14 universal among transgender men who do not want to appear female. Binding can be extremely
15 uncomfortable, considering that binders are hot and itchy, and can cause serious harm. Over a
16 period of time, binding can affect skin, muscles and movement. Two recent studies, examined the
17 negative effects of binding on data collected from 1,800 transgender males. Of these participants,
18 76-78% experienced skin or tissue related problems: including scarring, swelling, infection; 74-
19 75% reported pain in the chest, shoulders, back or abdomen; 51-52% reported shortness of breath;
20 and 47-49% reported musculoskeletal injuries, including muscle wasting (Peitzmeir et al., 2017;
21 Jarrett et al., 2018). Yet, many transgender men are so intensely uncomfortable with their breasts
22 that they are willing to suffer alarming rampant infection, dyspnea (shortness of breath) and even
23 fractured ribs, to conceal breast tissue (Ettner, 2016).
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1 79. In 2019, C.P. underwent medically indicated chest reconstruction to avoid these
2 hazards.

3 80. At 17 years of age, C.P. is five feet nine inches and weighs 152 pounds. He is
4 indistinguishable from his male peers. C.P. is an excellent student, and works as a lifeguard and
5 swim instructor at a local YMCA. C.P. has never been diagnosed with any mental health issues,
6 and does not use recreational drugs, tobacco, or alcohol. He attends both high school and a
7 technical school in preparation for a career in fire-fighting.

8 81. Individuals like C.P. diagnosed with early-onset gender dysphoria that persists into
9 adolescence, typically suffer the most severe expression of the condition. By analogy, type-one
10 diabetes appears in childhood and differs from type-two diabetes, which typically is a disease
11 arising in adulthood. The treatment of the conditions can differ, with the latter often being less
12 severe and not necessarily requiring insulin. The appropriate, medically necessary treatment that
13 C.P. received, and the treatments he may require in the future, allow him to fulfill his potential and
14 to focus on the normal challenges of life, such as making a living and forming relationships.
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EXHIBIT A

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

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of
Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association for Transgender Health
(WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee Curriculum Development, 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 on women's health issues
Private practitioner
Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago,
IL
Advisory Council, National Center for Gender Spectrum Health
Global Clinical Practice Network; World Health Organization

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

- 2016-2022 Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
Consultant: Walgreens; Tawani Enterprises
Private practitioner/ Supervision
- 2011 Instructor, Prescott College: Gender-A multidimensional approach
- 2000 Instructor, Illinois School of Professional 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

Sexual Function: Expectations and outcomes for patients undergoing gender-affirming surgery. Whitney, N., Ettner, R., Schechter, L. Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

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

Expectations of individuals undergoing gender-confirming surgeries Schechter, L., White, T., Ritz, N., Ettner, R. Buenos Aires, 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; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Can two wrongs make a right? Expanding models of care beyond the divide, 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

Transgender surgery- Midwestern Association of Plastic Surgeons, Chicago, 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, Chicago, 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, 2013

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

Grand Rounds: Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011

Grand Rounds: Evidence-based care of transgender patients Roosevelt-St. Vincent Hospital, New York, 2011

Grand Rounds: Evidence-based care of transgender patients Columbia Presbyterian Hospital, Columbia University, New York, 2011

Hypertension: Pathophysiology of a secret. WPATH symposium, Atlanta, GA, 2011

Exploring the Clinical Utility of Transsexual Typologies Oslo, Norway, 2009

*Children of Transsexuals-*International Association of Sex Researchers, Ottawa, Canada, 2005

Children of Transsexuals Chicago School of Professional Psychology, Chicago, 2005

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

*Gender Identity, Gender Dysphoria and Clinical Issues –*WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory

University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

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

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

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

Grand Rounds: 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

Robles, C., Hamidian, A., Ferragamo, B., Radix, A., De Cuypere, G., Green, J., Ettner, R., Monstrey, S., Schechter, L. Gender affirmation surgery: A collaborative approach between the surgeon and the mental health professional. *Journal of Plastic and Reconstructive Surgery* in press.

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Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium*, 31-32.

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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, Institute for Sexual and Gender Health; *50 Distinguished Sex and Gender Revolutionaries* award, 2021

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016

Phi Beta Kappa, 1972

Indiana University Women's Honor Society, 1970-1972

Indiana University Honors Program, 1970-1972

Merit Scholarship Recipient, 1970-1972

Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972

Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

EXHIBIT B

BIBLIOGRAPHY

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C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

REDACTED COPY

Exhibit 7

The Honorable Robert J. Bryan

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9
**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA**

10 C. P., by and through his parents, Patricia
11 Pritchard and Nolle Pritchard; and PATRICIA
PRITCHARD,

12 Plaintiffs,

13 v.

14 BLUE CROSS BLUE SHIELD OF ILLINOIS,

15 Defendant.

No. 3:20-cv-06145-RJB

16
17
EXPERT REPORT OF DAN H. KARASIC, M.D.

18 I, Dan H. Karasic, M.D., hereby declare and state as follows:

19 1. I have been retained by counsel for Plaintiffs as an expert in connection with the
20 above-captioned litigation.

21 2. I have actual knowledge of the matters stated herein. If called to testify in this
22 matter, I would testify truthfully and based on my expert opinion.

1 **I. BACKGROUND AND QUALIFICATIONS**

2 **A. Qualifications**

3 3. The information provided regarding my professional background, experiences,
4 publications, and presentations are detailed in my curriculum vitae (“CV”). A true and correct
5 copy of my most up-to-date CV is attached as **Exhibit A**.

6 4. I am a Professor Emeritus of Psychiatry at the UCSF Weill Institute for
7 Neurosciences. I have been on faculty at the University of California – San Francisco since 1991.
8 I have also had a telepsychiatry private practice since 2020.

9 5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in
10 1987. In 1991, I completed my residency in psychiatry at the University of California – Los
11 Angeles Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a
12 training program in mental health services for persons living with AIDS at UCLA.

13 6. For over 30 years, I have worked with patients with gender dysphoria. I am a
14 Distinguished Fellow of the American Psychiatric Association and currently the chair of the
15 American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of
16 the chapter on transgender care in the American Psychiatric Press’s Clinical Manual of Cultural
17 Psychiatry, Second Edition.
18

19 7. Over the past 30 years, I have provided care for thousands of transgender patients.
20 For 17 years, I was the psychiatrist for the Dimensions Clinic for transgender youth in San
21 Francisco.
22

23 8. I previously sat on the Board of Directors of the World Professional Association
24 for Transgender Health (WPATH) and am a co-author of WPATH’s *Standards of Care for the*
25 *Health of Transsexual, Transgender, and Gender Nonconforming People*, Version 7, which are
26

1 the internationally accepted guidelines designed to promote the health and welfare of transgender,
2 transsexual, and gender variant persons. I remain active in the work of WPATH. For the upcoming
3 WPATH Standards of Care, Version 8, I am the lead author on the Mental Health chapter.

4 9. As a member of the WPATH Global Education Initiative, I helped develop a
5 specialty certification program in transgender health and helped train over 2,000 health providers.
6 At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at
7 the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of
8 Excellence for Transgender Care, and co-wrote the mental health section of the original *Guidelines*
9 *for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* and
10 the revision in 2016.
11

12 10. I have also worked with the San Francisco Department of Public Health, having
13 developed and implemented their training program for the care of transgender patients and for
14 mental health assessments for gender-affirming surgery. I served on the City and County of San
15 Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert
16 consultant for California state agencies and on multiple occasions for the United Nations
17 Development Programme on international issues in transgender care.
18

19 11. I have held numerous clinical positions concurrent to my clinical professorship at
20 UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's
21 consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at
22 UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at
23 Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's
24 Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of
25 transgender, gender dysphoric, and HIV-positive patients. I also regularly provide consultation on
26

1 challenging cases to psychologists and other psychotherapists working with transgender and
2 gender dysphoric patients. I have been a consultant in transgender care to the California
3 Department of State Hospitals and am currently a consultant for the California Department of
4 Corrections and Rehabilitation on the care of incarcerated transgender people.

5 12. In addition to this work, I have done research on the treatment of depression. I have
6 authored many articles and book chapters, and edited the book *Sexual and Gender Diagnoses of*
7 *the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

8
9 **B. Compensation**

10 13. I am being compensated for my work on this matter at a rate of \$400.00 per hour
11 for preparation of declarations and expert reports. I will be compensated \$3,200.00 per day for any
12 deposition testimony or trial testimony. My compensation does not depend on the outcome of this
13 litigation, the opinions I express, or the testimony I may provide.

14 **C. Previous Testimony**

15 14. Over the past four years, I have given expert testimony at trial or by deposition
16 in the following cases: *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.). To the best of my
17 recollection, I have not given expert testimony at a trial or at a deposition in any other case
18 during this period.

19
20 **II. BASIS FOR OPINIONS**

21 15. In preparing this report, I have relied on my training and years of research and
22 clinical experience, as set out in my curriculum vitae, and on the materials listed therein, as
23 documented in my curriculum vitae, which is attached hereto as **Exhibit A**.

24 16. I have also reviewed the materials listed in the bibliography attached hereto as
25 **Exhibit B**. The sources cited therein include authoritative, scientific peer-reviewed publications.
26

1 They include the documents specifically cited as supportive examples in particular sections of this
2 report.

3 17. I also rely upon my interview of C.P., on March 18, 2022, and C.P.’s mental health
4 and medical records.

5 18. Additionally, I have reviewed the Amended Class Action Complaint (ECF No. 38)
6 and the court’s Order Denying Defendant’s Motion to Dismiss (ECF No. 23) in this case.

7 19. The materials I have relied upon in preparing this report are the same types of
8 materials that experts in my field of study regularly rely upon when forming opinions on the
9 subject. I reserve the right to revise and supplement the opinions expressed in this report or the
10 bases for them if any new information becomes available in the future, including as a result of new
11 scientific research or publications or in response to statements and issues that may arise in my area
12 of expertise.
13

14 **III. EXPERT OPINIONS**

15 **A. Gender Identity**

16 20. Sex assigned at birth refers to the sex assigned to a person at the time of their birth,
17 typically based on the appearance of external genital characteristics. While the terms “male sex”
18 and “female sex” are sometimes used in reference to a person’s genitals, chromosomes, and
19 hormones, the reality is that sex is complicated and multifactorial. Aside from external genital
20 characteristics, chromosomes, and endogenous hormones, other factors related to sex include
21 gonads, gender identity, and variations in brain structure and function. Because these factors may
22 not always be in alignment as typically male or typically female, “the terms biological sex and
23 biological male or female are imprecise and should be avoided.” (Hembree, et al., 2017).
24
25
26

1 21. Gender identity is “a person’s deeply felt, inherent sense of being a girl, woman,
2 or female; a man, or male; a blend of male or female; or an alternative gender” (American
3 Psychological Association, 2015, at 834). Gender identity does not always align with sex assigned
4 at birth. Gender identity, which has biological bases, is not a product of external influence and not
5 subject to voluntary change. As documented by multiple leading medical authorities, efforts to
6 change a person’s gender identity are ineffective, can cause harm, and are unethical. (American
7 Psychological Association, 2021, Byne, et al., 2018, Coleman, et al., 2012).

8 **B. Gender Dysphoria**

9
10 22. The term “gender dysphoria” (uncapitalized) is distress related to the incongruence
11 between one’s gender identity and attributes related to one’s sex assigned at birth.

12 23. The diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual Fifth
13 Edition (DSM-5), released in 2013, involves two major diagnostic criteria for adolescents and
14 adults:

15 A. A marked incongruence between one’s experienced/expressed gender and
16 assigned gender, of at least 6 months duration, as manifested by at least two of
17 the following (one of which must be Criterion A1):

- 18
- 19 1. A marked incongruence between one’s experienced/expressed gender and
20 primary or secondary sex characteristics.
 - 21 2. A strong desire to be rid of one’s primary and/or secondary sex
22 characteristics because of a marked incongruence with one’s
23 experienced/expressed gender.
 - 24 3. A strong desire for the primary and/or secondary sex characteristics of the
25 other gender.
26

1 4. A strong desire to be of the other gender (or some alternative gender
2 different from one's assigned gender).

3 5. A strong desire to be treated as the other gender (or some alternative gender
4 different from one's assigned gender).

5 6. A strong conviction that one has the typical feelings and reactions of the
6 other gender (or some alternative gender different from one's assigned
7 gender).

8 B. The condition is associated with clinically significant distress or impairment in
9 social, occupational, or other important areas of functioning.
10

11 24. Given that gender dysphoria can cause such distress, many transgender individuals
12 face depression, anxiety, and higher rates of suicidality than cisgender people. This is noted both
13 in adults and adolescents. However, gender dysphoria is a condition that is highly amenable to
14 treatment, and the prevailing treatment for it is highly effective. The aforementioned risks do
15 decline when transgender individuals are supported and live according to their gender identity.
16 And with access to medically indicated care, transgender people can experience significant and
17 potentially complete relief from their symptoms of gender dysphoria. Not only is this documented
18 in scientific literature and published data, but I witness this each time I see my patients being
19 supported by their community, family, school, and medical providers.
20

21 **C. Evidence-Based Guidelines for Treatment of Gender Dysphoria**

22 25. The World Professional Association of Transgender Health (WPATH) has issued
23 *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming*
24 *People* ("WPATH SOC") since 1979. The current version is WPATH SOC 7, with WPATH SOC
25 8 due out in Spring 2022. WPATH SOC 7 provides guidelines for multidisciplinary care of
26

1 transgender individuals and describes criteria for medical interventions to treat gender dysphoria,
2 including hormone treatment and surgery when medically indicated.

3 26. WPATH SOC 7 also states, “Treatment aimed at trying to change a person’s gender
4 identity and expression ... is no longer considered ethical,” because it is known to be ineffective
5 and can cause harm to patients.

6 27. A clinical practice guideline from the Endocrine Society (the Endocrine Society
7 Guideline) provides similar protocols for the medically necessary treatment of gender dysphoria.
8 (Hembree, et al., 2017).
9

10 28. Guidelines from other organizations, including those developed by the UCSF
11 Center of Excellence for Transgender Care, also list similar protocols for the medically necessary
12 treatment of gender dysphoria.

13 29. Each of these guidelines are evidence-based and supported by scientific research
14 and literature, as well as extensive clinical experience.

15 30. The protocols and policies set forth by the WPATH Standards of Care and the
16 Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional
17 medical and mental health associations in the United States, including the American Medical
18 Association, the American Academy of Pediatrics, the American Psychiatric Association, the
19 American Psychological Association, the American College of Obstetrics and Gynecology, the
20 American College of Physicians, and the World Medical Association, among others.
21

22 31. To be sure, being transgender is widely accepted as a variation in human
23 development and is not considered a mental illness. People who are transgender have no
24 impairment in their ability to be productive, contributing members of society simply because of
25 their transgender status.
26

- 1 a. The American Psychiatric Association’s DSM 5 states: Gender dysphoria “is more
2 descriptive than the previous DSM-IV term ‘gender identity disorder’ and focuses
3 on dysphoria as the clinical problem, not identity per se.” (APA, 2013).
- 4 b. WPATH SOC 7 states: “Being transsexual, transgender, or gender-nonconforming
5 is a matter of diversity, not pathology.... Thus, transsexual, transgender, and
6 gender-nonconforming individuals are not inherently disordered. Rather, the
7 distress of gender dysphoria, when present, is the concern that might be
8 diagnosable and for which various treatment options are available.”
- 9 c. The American Psychological Association states: “Whereas diversity in gender
10 identity and expression is part of the human experience and transgender and gender
11 nonbinary identities and expressions are healthy, incongruence between one’s sex
12 and gender is neither pathological nor a mental health disorder.” (American
13 Psychological Association, 2021).
- 14 d. The World Health Organization states: “Gender incongruence has thus broadly
15 been moved out of the ‘Mental and behavioural disorders’ chapter and into the new
16 ‘Conditions related to sexual health’ chapter. This reflects evidence that trans-
17 related and gender diverse identities are not conditions of mental ill health, and
18 classifying them as such can cause enormous stigma.” (WHO Europe).

19
20
21 32. Thus, the overarching goal of treatment is to eliminate the distress of gender
22 dysphoria by aligning an individual patient’s body and presentation with their internal sense of
23 self. The denial of medically indicated care to transgender people not only results in the prolonging
24 of their gender dysphoria, but causes additional distress and poses other health risks, such as
25 depression, posttraumatic stress disorder, and suicidality. In other words, lack of access to gender-
26

1 affirming care directly contributes to poorer mental health outcomes for transgender people.
2 (Owen-Smith, et al., 2018).

3 33. For patients for whom gender-affirming medical care is indicated, no alternative
4 treatments have been demonstrated to be effective. The American Psychological Association states
5 that gender identity change efforts provide no benefit and instead do harm. (American
6 Psychological Association, 2021).

7 34. Accordingly, major medical organizations, such as the American Medical
8 Association, American Psychiatric Association, the Endocrine Society, American College of
9 Obstetricians and Gynecologists, and American Academy of Family Physicians oppose the denial
10 of this medically necessary care and support public and private health insurance coverage for
11 treatment of gender dysphoria as recommended by the patient's physician. (American Medical
12 Association, 2021; American Psychiatric Association, 2018; Endocrine Society, 2012; American
13 College of Obstetricians and Gynecologists, 2021; American Academy of Family Physicians,
14 2020).

15
16 **D. Treatment of Gender Dysphoria**

17 35. The WPATH SOC 7 and the Endocrine Society Guidelines establish authoritative
18 protocols for the treatment of gender dysphoria.
19

20 36. In accordance with the WPATH SOC 7 and the Endocrine Society Guidelines,
21 medical interventions to treat gender dysphoria may include treatment with pubertal suppression
22 and/or hormones, and treatment with surgery.

23 37. No medical or surgical treatment for gender dysphoria is provided to pre-pubertal
24 children.
25
26

1 38. Once a patient enters puberty, treatment options include pubertal suppression
2 therapy and gender affirming hormones. Pubertal blocking involves methods of temporarily
3 suppressing endogenous puberty to alleviate gender dysphoria and give the patient more time to
4 work with their mental health providers to assess treatment needs. These blockers are reversible
5 medications and once stopped, a patient immediately returns to the stage of pubertal development
6 that had begun when the treatment was initiated.

7 39. If a patient is assessed to have a medical need for hormone therapy, gender
8 affirming hormone therapy involves administering steroids of the experienced sex (i.e., their
9 gender identity), such as testosterone in transgender male individuals and estrogen in transgender
10 female individuals may be used to treat gender dysphoria later in puberty. The purpose of this
11 treatment is to attain the appropriate masculinization or feminization of the transgender person to
12 achieve a gender phenotype that matches as closely as possible to their gender identity. For
13 adolescents, this treatment allows patients to have pubertal changes and development consistent
14 with their gender identity. Gender affirming hormone therapy is a partially reversible treatment in
15 that some of the effects produced by the hormones are reversible (e.g., changes in body fat
16 composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the
17 voice, decreased testicular mass).

18 40. Some transgender individuals need surgical interventions to help bring their
19 phenotype into alignment with their gender. Surgical interventions may include vaginoplasty,
20 tracheal shave, liposuction, breast implants, and orchiectomy for transgender female individuals
21 and chest reconstruction, hysterectomy, oophorectomy, salpingectomy, construction of
22 neoscrotum, and metoidioplasty or phalloplasty for transgender male individuals.
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1 41. For some older transgender male adolescents, chest surgery may be provided prior
2 to age 18 if medically indicated.

3 42. The treatment protocols for gender dysphoria are comparable to those for other
4 mental health and medical conditions. Indeed, these or similar procedures are provided for
5 cisgender people with other diagnoses.

6 **E. Gender-Affirming Medical and Surgical Care Is Safe and Effective.**

7 43. Gender-affirming medical and surgical interventions in accordance with the
8 WPATH SOC 7 and Endocrine Society Guidelines are widely recognized in the medical
9 community as safe, effective, and medically necessary for many transgender people with gender
10 dysphoria. (See American Academy of Pediatrics, 2018; the American Medical Association, 2021;
11 the Endocrine Society, 2020, the Pediatric Endocrine Society, 2021; the American Psychiatric
12 Association, 2018; the American Psychological Association, 2021; the American Congress of
13 Obstetricians and Gynecologists, 2021; the American Academy of Family Physicians, 2020;
14 WPATH, 2012).

15 44. There is substantial evidence that gender-affirming medical and surgical care is
16 effective in treating gender dysphoria. This evidence includes scientific studies assessing mental
17 health outcomes for transgender people who are treated with these interventions, including
18 adolescents, and decades of clinical experience.

19 45. The research and studies supporting the necessity, safety, and effectiveness of
20 medical and surgical care for gender dysphoria are the same type of evidence-based data that the
21 medical community routinely relies upon when treating other medical conditions.

22 46. Medical treatment for gender dysphoria has been studied for over half a century,
23 and there is substantial evidence that it improves quality of life and measures of mental health.
24
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1 (Aldridge et al., 2020; Almazan, et al., 2021; Baker et al., 2021; Murad, et al., 2010; Nobili et al.,
2 2018; Pfafflin & Junge, 1998; T’Sjoen et al. 2019; van de Grift et al., 2018; White Hughto and
3 Reisner, 2016; Wierckx et al., 2014).

4 47. A systematic review of 20 studies showed improved quality of life, decreased
5 depression, and decreased anxiety with hormonal treatment in transgender people. (Baker, et al.,
6 2021). Another systematic review showed improvement in mental health and quality of life
7 measures in transgender people with hormonal treatment (White Hughto and Reisner, 2016). In
8 the United Kingdom, one study demonstrated that depression and anxiety were substantially
9 reduced over 18 months of gender-affirming hormonal treatment. (Aldridge, et al., 2020). In a
10 secondary analysis of data from the US Transgender Survey, having had genital surgery was
11 associated with decreased psychological distress and suicidal ideation. (Almazan, et al., 2021). In
12 transgender patients followed 4-6 years after surgery, satisfaction was very high (over 90%) and
13 regret was low. (van de Grift et al., 2018). The Cornell “What We Know” systematic review of 55
14 studies from 1991-2017 strongly supported that gender-affirming hormone and surgical treatment
15 improved the well-being of transgender individuals. (What We Know, 2018).
16

17 48. The studies on gender-affirming medical care for treatment of dysphoria are
18 consistent with decades of clinical experience of mental health providers across the U.S. and
19 around the world. At professional conferences and other settings in which I interact with
20 colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated,
21 provides great clinical benefit. In my 30 years of clinical experience treating gender dysphoric
22 patients, I have seen the benefits of gender-affirming medical care on my patients’ health and well-
23 being. I have seen many patients show improvements in mental health, as well as in performance
24
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1 in school, in social functioning with peers, and in family relationships when they experience relief
2 from gender dysphoria with gender-affirming medical care.

3 49. Accordingly, treatments for gender dysphoria are not considered elective or
4 cosmetic. Indeed, as WPATH (2016) states, “The medical procedures attendant to gender
5 affirming/confirming surgeries are not ‘cosmetic’ or ‘elective’ or ‘for the mere convenience of the
6 patient.’ These reconstructive procedures are not optional in any meaningful sense, but are
7 understood to be medically necessary for the treatment of the diagnosed condition. In some cases,
8 such surgery is the only effective treatment for the condition, and for some people genital surgery
9 is essential and life-saving.”
10

11 50. As part of the treatment process for gender dysphoria, patients provide informed
12 consent to their care. In addition, a treating doctor will not offer gender-affirming medical
13 treatments unless they have concluded after weighing the risks and benefits of care that treatment
14 is appropriate. The risks and benefits of care are discussed with the transgender patient, who must
15 assent. This process is no different than the informed consent process for other treatments.
16 However, for gender-affirming medical care, there is the additional safeguard of the assessment
17 by a mental health professional, who, in addition to diagnosing gender dysphoria, also assesses
18 capacity to consent and reviews the risks and benefits of treatment with the patient.
19

20 51. Regret among those who are treated with gender-affirming medical care is rare.
21 For example, in one study in the Netherlands, none of the youth who received puberty blockers,
22 hormones, and surgery, and followed over an 8-year period expressed regret. (DeVries, 2014.)
23 Zucker, et al., (2010), summarizing key studies on regret for adolescents referred for surgery when
24 they reached the age of majority in the Netherlands, states, “there was virtually no evidence of
25 regret, suggesting that the intervention was effective.”
26

1 52. Regret rates for gender-affirming surgery in adults are also very low. A pooled
2 review across multiple studies of 7,928 patients receiving gender-affirming surgery showed a
3 regret rate of 1%. (Bustos, et al., 2021). Over 50 years of gender-affirming surgery in Sweden, the
4 regret rate, as measured by legal gender change reversal, was 2%. (Dhejne, et al., 2014). These are
5 very low regret rates for surgery. For example, 47% of women expressed at least some regret after
6 reconstructive breast surgery following mastectomy for breast cancer. (Sheehan, et al., 2008).

7 53. For all the reasons above, I am aware of no basis in medicine or science for
8 categorical exclusion of coverage for gender-affirming care, such as the exclusion contained in the
9 Catholic Health Initiatives Medical Plan administered by Blue Cross Blue Shield of Illinois.
10

11 54. One misperception is that hormone therapy is experimental because the U.S. Food
12 and Drug Administration (“FDA”) has not yet approved its use for the specific application of
13 treating Gender Dysphoria. Medications very commonly are prescribed for off-label uses. Many
14 gender-affirming hormone treatments were approved for treatment of other conditions and have
15 been used for those conditions as well as for gender-affirming care for many years, supporting
16 their safety and efficacy. The U.S. Department of Health and Human Services Agency for
17 Healthcare Research and Quality states, “[Off-label prescribing] is legal and common. In fact, one
18 in five prescriptions written today are for off-label use.”¹
19

20 55. Finally, the cost of providing gender-affirming care is generally very low,
21 particularly in the context coverage through group health plans. To begin, transgender people
22 constitute a small percentage of the overall population, approximately 0.5%. (Crissman, et. al.,
23 2017). Furthermore, the fraction of the population receiving clinical care for Gender Dysphoria is
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¹ See <https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html>.

1 much smaller, well under one in a thousand patients (Zhang, et al., 2020). As a result, one study
2 estimated an average cost of \$0.016 cents per member per month to provide gender-affirming care.
3 (Padula, et al., 2016). The authors conclude: “Health insurance coverage for the U.S. transgender
4 population is affordable and cost-effective, and has a low budget impact on U.S. society.” A study
5 by Herman (2013) similarly found low costs to providing health coverage for gender affirming
6 care. Additionally, when a form of treatment is covered for cisgender people under an insurance
7 plan, it is generally not disproportionately costly to cover the same treatment for transgender
8 people simply because it is provided to treat gender dysphoria.
9

10 **F. Harms of Denying Gender-Affirming Care**

11 56. The overarching goal of treatment is to eliminate the distress of gender dysphoria
12 by aligning an individual patient’s body and presentation with their internal sense of self. The
13 denial of medically indicated care to transgender people not only results in the prolonging of their
14 gender dysphoria, but causes additional distress and poses other health risks, such as depression,
15 posttraumatic stress disorder, and suicidality. The prevalence of these mental health conditions is
16 widely thought to be a consequence of minority stress, the chronic stress from coping with societal
17 stigma and discrimination because of one’s identity, including gender identity and gender
18 expression. (American Medical Association, 2019). In other words, lack of access to gender-
19 affirming care directly contributes to poorer mental health outcomes for transgender people.
20 (Owen-Smith, et al., 2018).
21

22 57. Accordingly, major medical organizations, such as the American Medical
23 Association, American Psychiatric Association, and American College of Obstetricians and
24 Gynecologists, oppose the denial of this medically necessary care and support public and private
25
26

1 health insurance coverage for treatment of gender dysphoria as recommended by the patient's
2 physician. (American Medical Association, 2019).

3 58. Denial of this appropriate care for transgender adolescents is also opposed by
4 mainstream organizations responsible for the care of youth, including the American Academy of
5 Pediatrics, the Academy of Child and Adolescent Psychiatry, and the Pediatric Endocrine Society.

6 59. Familial and social support and the provision of gender-affirming medical
7 treatment have been associated with dramatically less suicidal ideation in transgender people.
8 (Bauer, et al., 2015). Provision of puberty blockers for transgender youth likewise decreases
9 suicidality (Tordoff, et al., 2022; Turban, et al., 2020). The American Academy of Child and
10 Adolescent Psychiatry states, "Research consistently demonstrates that gender diverse youth who
11 are supported to live and/or explore the gender role that is consistent with their gender identity
12 have better mental health outcomes than those who are not." (AACAP, 2019).

13 60. In a University of Washington study of 104 transgender and nonbinary youth,
14 treatment with puberty blockers or hormones was associated with 60% less moderate to severe
15 depression and 73% less suicidal ideation over 12 months, compared to youth not treated.
16 (Tordoff, et al. 2022).

17 61. In a University of Texas Southwestern study, treatment with gender affirming
18 hormones in transgender youth was associated with a substantial reduction in body dissatisfaction,
19 as well as improvement on measures of depression and anxiety. (Kuper, et al., 2020).

20 62. In a University of Southern California and Children's Hospital Los Angeles study
21 of 136 transgender male youth, the half that had received chest masculinizing surgery had far less
22 gender dysphoria than those who had not yet had surgery. (Olson et al, 2018).
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1 63. In a University of Pennsylvania and University of Rochester study, transgender
2 male youth aged 13-21 suffered substantial emotional distress and functional impairment from
3 dysphoria related to their chest. Chest dysphoria resolved with surgery. Youth reported
4 improvement functionally and in quality of life (Mehringer et al 2021).

5 64. In the past 10 years, there has been a reversal in longstanding policies that had
6 excluded reimbursement for transgender people. There are many more clinics providing care to
7 transgender youth and adults in academic medical centers than a decade ago, because funding is
8 now available. This change is allowing clinical researchers to expand the body of research in the
9 United States, as well as increasing access to care.
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IV. ASSESSMENT OF PLAINTIFF C.P.

65. Section IV of this report is designated as **CONFIDENTIAL** pursuant to the **Protective Order in this matter (ECF No. 25)**.

66. C [REDACTED] P [REDACTED] DOB: [REDACTED] 2005

67. C [REDACTED] P [REDACTED] is a 17-year-old male evaluated on 3/18/22 via Zoom. His parents were present at the beginning and end of the session. C [REDACTED]'s medical records were reviewed before the session.

68. C [REDACTED] was assigned female at birth. He describes himself as a “tomboy” as a young child. He states he first had his hair cut short in third or fourth grade and felt it was more congruent with who he was. He states he didn’t fit in with the girls or their interests and related instead to boys. He preferred wearing boys’ clothes and not girls’ clothes. His mother stated that she bought him a magenta bicycle and he “was devastated and wanted to paint it.” He was highly interested in athletics, but quit the girls softball team.

69. His parents took him to a gender diversity group, for transgender youth and their families, at age 10, and he learned about the option of medical intervention. At age 10, in September 2016, he first saw Dr. Kevin Hatfield, and in November, 2016, he was started on a Vantas (histrelin) implant. He had started to have breast growth, which was uncomfortable and distressing. With histrelin, the breast growth stopped, and he was relieved to not start menstruation. C [REDACTED] reports that knowing his breasts wouldn’t grow more and that he wouldn’t menstruate relieved the anxiety he was having about changes in his body with puberty.

70. In April-May 2017, C [REDACTED] started on testosterone cream, which allowed him to feel he was experiencing puberty with other boys. C [REDACTED] was switched to testosterone injections in January 2019. C [REDACTED] states that Dr. Hatfield discussed the risks and benefits of each

1 intervention extensively with C [REDACTED] and his parents. C [REDACTED] experienced lowered voice, increased
2 weight and musculature on working out, and hair growth. He reports these changes decreased
3 gender dysphoria.

4 71. Though breast growth was halted with histrelin, the breast growth he had before
5 starting treatment remained uncomfortable and distressing. His breasts were out of line with how
6 he saw himself, and how he wanted others to see him. C [REDACTED] was very aware of his breasts; he
7 felt uncomfortable taking his shirt off at his cousin's lake house. He was active in sports and felt
8 a binder would be uncomfortable and noticeable if he wanted to swim. He felt that his breasts
9 limited his activity and his ability to have a boyhood like his peers.
10

11 72. C [REDACTED] had gender affirming chest surgery in 2019. He was very happy with the
12 results, feeling a great decrease in gender dysphoria. In July 2021 he worked as a lifeguard and
13 swim instructor, and plays tennis. C [REDACTED] was able to have a keyhole procedure rather than a double
14 incision mastectomy because he started puberty blockers before his breast grew too large for the
15 keyhole procedure. Because of this his scars are much smaller and less noticeable than they would
16 have been otherwise. C [REDACTED] states his only regret about his treatment is that he wasn't started on
17 puberty blockers earlier, so that he would not have needed chest surgery.
18

19 73. C [REDACTED] gets good grades in school and plans to become a firefighter.

20 74. No mental health history other than gender dysphoria and seeing a mental health
21 professional before gender affirming care, as well as being assessed for Attention Deficit
22 Hyperactivity Disorder.

23 75. In summation, C [REDACTED] P [REDACTED] is a 17-year-old transgender male. At the times of
24 treatment with puberty blockers, testosterone treatment, and chest surgery, he experienced
25 clinically significant distress and social impairment consistent with a DSM-5 diagnosis of Gender
26

1 Dysphoria. He met WPATH Standards of Care 7 criteria for each intervention. Treatment with
2 puberty blockers, testosterone, and chest surgery were medically necessary treatments. His
3 symptoms of Gender Dysphoria are substantially improved with treatment.

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V. CONCLUSION

76. The categorical exclusions of coverage for gender-affirming care contained in plans administered by Blue Cross Blue Shield of Illinois, such as the Catholic Health Initiatives Medical Plan’s exclusion for “Transgender Reassignment Surgery,” bar coverage for medical treatments that are part of widely accepted medical protocols for the treatment of transgender people with gender dysphoria that are recognized by major medical and mental health professional associations in the United States.

77. The accepted protocols for the treatment of transgender people with gender dysphoria provide for mental-health assessments, including of co-occurring conditions; criteria for eligibility for each treatment; and an informed consent process before medical interventions are initiated.

78. Decades of medical research and clinical experience have demonstrated that the medical treatments barred from coverage by the Exclusion are safe, effective, and medically necessary to relieve gender dysphoria for transgender people.

79. Denying gender-affirming medical care to transgender people for whom it is medically indicated puts them at risk of significant harm to their health and wellbeing, including heightened risk of depression and suicidality.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 4 day of April, 2022.



Dan H. Karasic, M.D.

EXHIBIT A

**University of California, San Francisco
CURRICULUM VITAE**

Name: Dan H. Karasic, MD

Position: Professor Emeritus
Psychiatry
School of Medicine

Voice: 415-935-1511

Fax: 888-232-9336

EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clinical Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor
1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry

		Associate Clinical Professor	
2005 - present	University of California, San Francisco	Health Sciences Psychiatry Clinical Professor	

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry Francisco
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health Center	Psychiatrist Clinic	Dimensions Dimensions
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
1990	NIMH Postdoctoral Fellowship in Mental Health Services for People with	National Institute of Mental Health

	AIDS (1990-1991)	
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF

KEYWORDS/AREAS OF INTEREST

Psychiatry, HIV/AIDS, consultation-liaison, medication adherence, gay/lesbian, transgender, gender dysphoria, sexuality, homeless/marginally housed, mood disorders, teaching/supervision

CLINICAL ACTIVITIES SUMMARY

As psychiatrist for the Positive Health Practice at Ward 86, I evaluated and treated patients with psychiatric illness and HIV. I provide consultation to internists, fellows, and nurse practitioners on managing psychiatric illness in their patients. Clinical work includes attention to the needs of special populations, including working with a multidisciplinary team in a drop-in clinic for HIV-positive women, and addressing issues emerging in HIV and Hepatitis C co-infection. As psychiatrist at the UCSF Alliance Health Project, I evaluated and treated patients and I am co-chair of the Gender Team, which provides assessment and care for transgender patients. As psychiatrist for the Transgender Life Care program and Dimensions Clinic, I evaluate and treat transgender patients, working with a multidisciplinary team at Castro Mission Health Center. In my faculty practice, I treated transgender, gender dysphoric, and HIV-positive patients referred from providers across Northern California, and I provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients.

MEMBERSHIPS

1992 - present Northern California Psychiatric Society

1992 - present American Psychiatric Association

2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)

2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator
1992 - 1996	Early Career Psychiatrist Committee, Association of Gay and Lesbian Psychiatrists	
1992 - 1996	Board of Directors, Association of Gay and Lesbian Psychiatrists	Member

1993 - 1993	Local Arrangements Committee, Association of Gay and Psychiatrists	Chair Lesbian
1994 - 1995	Educational Program, Association of Gay and Lesbian 1995 Annual Meeting	Director Psychiatrists,
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - present	Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society	Member
1995 - 1997	Board of Directors, Bay Area Young Positives. BAY Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth	President
1995 - 1997	Executive Committee, Bay Area Young Positives.	Chair
1996 - 2004	Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society	Chair
1998 - 2002	City of San Francisco Human Rights Commission, Lesbian, Gay Bisexual Transgender Advisory Committee	Member
2000 - 2004	Association of Gay and Lesbian Psychiatrists. for the organization's educational programs	Vice President Responsible
2004 - 2005	Association of Gay and Lesbian Psychiatrists	President-elect
2005 - 2007	Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the American Psychiatric Association	Chair
2005 - 2007	Association of Gay and Lesbian Psychiatrists	President
2007 - 2009	Association of Gay and Lesbian Psychiatrists	Immediate Past President
2009 - 2010	Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.)	Member
2010 - 2011	Scientific Committee, 2011 WPATH Biennial Symposium,	Member Atlanta
2010 -2022	World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing seventh and eighth revisions of the WPATH Standards of Care, which is used internationally for transgender care.)	Member
2010 - 2018	ICD 11 Advisory Committee, World Professional Association for Transgender Health	Member
2012 - 2014	Psychiatry and Diagnosis Track Co-chair, Scientific 2014 WPATH Biennial Symposium, Bangkok	Member Committee,
2014 - 2016	Scientific Committee, 2016 WPATH Biennial Symposium,	Member Amsterdam

2014 - 2018	Board of Directors (elected to 4 year term), World Professional Association for Transgender Health	Member
2014 - 2018	Public Policy Committee, World Professional Association for Transgender Health	Chair
2014 - 2018	WPATH Global Education Initiative: Training providers and specialty certification in transgender health	Trainer and Steering Committee Member
2014 - 2016	American Psychiatric Association Workgroup on Gender Dysphoria	Member
2016 - present	American Psychiatric Association Workgroup on Gender Dysphoria	Chair
2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

- 2011 - present Journal of Sexual Medicine, reviewer
- 2014 - present International Journal of Transgenderism, reviewer
- 2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Havana, Cuba	Invited Speaker
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Track Chair
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair

2015	Israeli Center for Human Sexuality and Gender Identity, Aviv	Invited Speaker Tel Aviv
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker
2017	Brazil Professional Association for Transgender Health, Paulo	Sao Paulo
2017	Vietnam- United Nations Development Programme Asia Transgender Health Conference, Hanoi	
2018	United Nations Development Programme Asia Conference on Transgender Health and Human Rights, Bangkok	
2018	World Professional Association for Transgender Health, Buenos Aires	Invited Speaker
2021	Manitoba Psychiatric Association, Keynote Speaker	

INVITED PRESENTATIONS - NATIONAL

1990	Being Alive Medical Update, Century Cable Television	Televised Lecturer
1992	Institute on Hospital and Community Psychiatry, Toronto	Symposium Speaker
1992	Academy of Psychosomatic Medicine Annual Meeting, San Diego	Symposium Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Chair
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Paper Session Co-chair
1995	Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach	Symposium Chair
1996	American Psychiatric Association 152nd Annual Meeting, New York	Workshop Speaker
1997	American Psychiatric Association Annual Meeting, San Diego	Workshop Speaker
1997	Gay and Lesbian Medical Association Annual	Invited Speaker Symposium
1998	American Psychiatric Association Annual Meeting,	Workshop Chair

	Toronto	
1998	American Psychiatric Association Annual Meeting, Toronto	Workshop Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists Symposium, New Orleans	Chair
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair

2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker
2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	Invited Speaker

		Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles	Course Faculty
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017	American Urological Association Annual Meeting, San Francisco CA Invited Speaker
2018	World Professional Association for Transgender Health GEI, Portland OR, Course Faculty
2018	World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty
2019	American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker
2019	American Psychiatric Association Annual Meeting, San Francisco, Session Chair
2020	Psychiatric Congress, Invited Speaker

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Symposium Speaker
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Workshop Panelist
1992	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1993	UCSF School of Nursing	Invited Lecturer
1995	UCSF/SFGH Department of Medicine Clinical Care Conference	Invited Speaker
1996	UCSF School of Nursing	Invited Speaker
1996	Psychopharmacology for the Primary Care AIDS/Clinician, Invited Lecturer series of four lectures, UCSF Department of Medicine	
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker

		Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics Rounds	Invited Speaker Grand
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee Chair Fall Symposium	
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	University of California, Davis, Department of Psychiatry Rounds	Invited Speaker Grand
1999	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker
2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker
2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker

2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco
2013	Association of Family and Conciliation Courts Conference, Angeles, CA	Invited Speaker Los
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker

		Invited Speaker
2014	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychaitry
2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	Invited Speaker
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference
2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco
2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA

2011 Transgender Mental Health Care Across the Life Span, Stanford University
2011 National Transgender Health Summit, San Francisco
2011 American Psychiatric Association Annual Meeting, Honolulu, HI
2011 World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011 Institute on Psychiatric Services, San Francisco
2012 Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013 National Transgender Health Summit, Oakland, CA
2013 American Psychiatric Association Annual Meeting, San Francisco
2013 Gay and Lesbian Medical Association, Denver, CO
2014 American Psychiatric Association Annual Meeting, New York
2014 Institute on Psychiatric Services, San Francisco
2015 European Professional Association for Transgender Health, Ghent, Belgium
2015 National Transgender Health Summit, Oakland
2015 American Psychiatric Association Annual Meeting, Toronto
2016 American Psychiatric Association Annual Meeting, Atlanta
2016 World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002 City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

SERVICE ACTIVITIES SUMMARY

My current service work focuses on developing transgender care at UCSF, nationally, and internationally.

I worked with urologist Maurice Garcia, MD on developing protocols as well as outcome measures for the UCSF Transgender Surgery Program at UCSF Medical Center. I am on the Medical Advisory Board of the UCSF Center of Excellence for Transgender Care, and have cowritten the mental health section of the original Primary Care Protocols and the new revision. I have chaired the Mental Health Track of UCSF's National Transgender Health Summit since its inception in 2011. I am a founder and co-chair of the Gender Team at the UCSF Alliance Health Project. I helped develop, and participated as a trainer, in the San Francisco

Department of Public Health provider training program for care of transgender patients and for mental health assessments for surgery, and have worked in program development for the SFDPH Transgender Health Services surgery program.

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course for the 2015 and 2016 APA Annual Meetings, and is now embarking on a larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.

I chaired the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 - present	HIV/AIDS Task Force	Member
1992 - 1993	HIV Research Group	Member
1992 - 1997	Space Committee	Member
1992 - present	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member
2010 - present	Steering Committee, Child Adolescent Gender Center	Member
2011 - present	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

1991 - present San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force

- 1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group
- 1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee
- 1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force
- 1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force
- 2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee
- 2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force
- 2014 - 2020 San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. *Diabetes*. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. *Journal of Neural Transmission. General Section*, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. *Psychosomatics*. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. *The Northern California Psychiatric Physician*. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. *Focus*. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. *Journal of the Gay and Lesbian Medical Association*. 1997 1(1) 41-47.
7. Karasic DH. Progress in health care for transgendered people. Editorial. *Journal of the Gay and Lesbian Medical Association*, 4(4) 2000 157-8.
8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. *Focus: A Guide to AIDS Research and Counseling*. 2002 17(9) 5-6.

9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. *International Journal of Transgenderism*. Volume 12, Issue 2. 2010, Pages 80-85.
10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. *International Journal of Transgenderism*, 13:165-232, 2011
11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. *American Journal of Public Health*. February 2013, Vol. 103, No. 2, pp. 308-315.
12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. *AIDS and Behavior*, October 2013, Volume 17, Issue 8, pp 2765-2772.
13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. *LGBT Health*. 2016 Aug; 3(4):245-7. PMID: 27458863
14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. *Lancet*. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925
15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. *AIDS Care*. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273
16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kushner ES, Mandel F, Caretto A, Lewis HC, Anthony LG. Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *J Clin Child Adolesc Psychol*. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428
17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. *J Sex Med* 2017;14:624–634.
18. **Karasic, DH** & Fraser, L. Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) *Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue*, Vol 45, Issue 3, pp 295-299. 2018 Elsevier, Philadelphia. <https://doi.org/10.1016/j.cps.2018.03.016>
19. Milrod C, Monto M, **Karasic DH**. Recommending or Rejecting "the Dimple": WPATH-Affiliated Medical Professionals' Experiences and Attitudes Toward Gender-Confirming Vulvoplasty in Transgender Women. [J Sex Med](#). 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.

BOOKS AND CHAPTERS

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.
2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkins, Philadelphia, 1999, pp. 577-584.
3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH**. The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D**. We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario <http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html>

2014 Cabading v California Baptist University

2014 CF v. Alberta

<http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html>

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan

2018 <https://canliiconnects.org/en/summaries/54130>

<https://canliiconnects.org/en/cases/2018skqb159>

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, *Kadel v. Folwell*, 1:19-cv-00272 (M.D.N.C.).

EXHIBIT B

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- Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA surgery*, 156(7), 611–618. <https://doi.org/10.1001/jamasurg.2021.0952>.
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- American Academy of Family Physicians (2020). Care for the Transgender and Nonbinary Patient, *available at* www.aafp.org/about/policies/all/transgender-nonbinary.html.
- American Academy of Pediatrics (2018). Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents, *available at* <https://pediatrics.aappublications.org/content/142/4/e20182162>.
- American College of Obstetricians and Gynecologists (2021). Committee Opinion No. 823: Health Care for Transgender and Gender Diverse Individuals, *available at* <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>.
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- American Medical Association and GLMA (2019). Issue Brief: Health insurance coverage for gender-affirming care of transgender patients, *available at* <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>.
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Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F. L., ... Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health*, 3(1), 57-70, *available at* <https://doi.org/10.1089/trgh.2017.0053>.

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Padula, W. V., Heru, S., & Campbell, J. D. (2016). Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. *Journal of general internal medicine*, *31*(4), 394–401. <https://doi.org/10.1007/s11606-015-3529-6>

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