

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA

KANAUTICA ZAYRE-BROWN,
Plaintiff,

v.

THE NORTH CAROLINA
DEPARTMENT OF ADULT
CORRECTION, *et al.*,

Defendants.

No. 3:22-cv-00191-MOC-DCK

PLAINTIFF'S DAUBERT MOTION TO EXCLUDE
THE TESTIMONY OF DR. SARA E. BOYD

Pursuant to Local Civil Rule 7.1, Federal Rule of Civil Procedure 7(b), Federal Rules of Evidence 702 and 703, and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), Plaintiff Kanautica Zayre-Brown hereby moves this Court to exclude the report and testimony of Defendants' expert Dr. Sara E. Boyd (Doc. 65-1) filed in support of Defendants' opposition to Plaintiff's motion for partial summary judgment. For the reasons stated in Plaintiff's brief filed in support of this motion, Dr. Boyd is not qualified to opine on the matters at issue, and her opinions lack a reliable basis and are ultimately irrelevant to the Court's consideration.

Respectfully submitted this 26th day of October 2023.

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CERTIFICATE OF SERVICE

I hereby certify that on October 26, 2023, I electronically filed the foregoing Plaintiff's *Daubert* Motion to Exclude the Testimony of Dr. Sara E. Boyd using the ECF system which will send notification of such filing to all counsel of record.

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA

CIVIL ACTION NO. 3:22-cv-00191

KANAUTICA ZAYRE-BROWN,)

)

Plaintiff,)

)

vs.)

)

THE NORTH CAROLINA)

DEPARTMENT OF PUBLIC)

SAFETY, ET AL.,)

)

Defendants.)

DEPOSITION OF
SARA BOYD, PH.D.

9:08 A.M.

FRIDAY, AUGUST 4, 2023

NORTH CAROLINA DEPARTMENT OF JUSTICE

114 WEST EDENTON STREET

RALEIGH, NORTH CAROLINA

CONTAINS GENERAL CONFIDENTIAL INFORMATION

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I N D E X

PAGE

EXAMINATION BY MR. SIEGEL

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E X H I B I T S

BOYD

NUMBER

DESCRIPTION

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EXHIBIT 1 Curriculum Vitae

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EXHIBIT 2 Expert Report of Sara E. Boyd,
Ph.D., ABPP

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EXHIBIT 3 Division Transgender
Accommodation Review Committee
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P R O C E E D I N G S

* * * *

SARA BOYD, PH.D.,

having been first sworn or affirmed by the court reporter and Notary Public to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. SIEGEL:

Q. All right. Dr. Boyd, good morning.

A. Good morning.

Q. Thank you for being here. We met just a minute ago, but I'll reintroduce myself for the record. My name is Dan Siegel and I'm one of the lawyers with the ACLU representing Kanautica Zayre-Brown --

A. Uh-huh.

Q. -- who's the plaintiff in this lawsuit. I'll be taking your deposition today. Before we get started, just a few housekeeping items to get out of the way.

First, just need to acknowledge for the record that since this lawsuit began, the North Carolina Department of Public Safety or DPS had a -- a reorganization and now the

1 defendant in this case is known as the North
2 Carolina Department of Adult Corrections or
3 DAC. So for purposes of this deposition, if
4 I refer to DPS or DAC, I'm referring to the
5 state prison system, the --

6 A. Right.

7 Q. -- defendant in this case.

8 Does that make sense?

9 A. Yes.

10 Q. Okay. Have you ever been deposed before?

11 A. Yes.

12 Q. About how many times?

13 A. I don't -- maybe -- over ten times, probably.

14 Q. Okay. So this will all just be review, but
15 I'm going to set out some --

16 A. Uh-huh.

17 Q. -- ground rules to help maybe move -- make
18 this go a little -- as smoothly as possible,
19 to make the court reporter's job a little
20 easier. First, I would just ask that you
21 answer all of my questions verbally instead
22 of giving an uh-huh or an uh-uh or shaking or
23 nodding your head and any other kind of
24 nonverbal response.

25 Does that make sense?

1 A. Yes.

2 Q. Okay. Great. The court reporter is taking
3 everything down so I would just ask that you
4 allow me to finish my question before you
5 begin your answer and, likewise, I will do my
6 best to let you finish your answer before I
7 an- -- ask my next question.

8 Make sense?

9 A. Yes.

10 THE WITNESS: I would also note that
11 sometimes I have a tendency to speak quickly
12 so if at any point I'm speaking too quickly,
13 please let me know.

14 BY MR. SIEGEL:

15 Q. If you do not understand a question that I
16 ask or you don't think you heard me quite
17 right or you need me to repeat it, please
18 just go ahead ask. I do not mind at all. If
19 you do answer my question, I will assume that
20 you heard it and understood it, okay?

21 A. Okay.

22 Q. We're going to be taking breaks throughout
23 the day. If there's ever a point when it's
24 not a designated break time and you would
25 like to take a break, that's totally fine.

1 We can do that. I would just ask that you
2 answer whatever question I had just asked
3 before we break.

4 A. Yes.

5 Q. Is that all right? Okay. During the
6 deposition your attorney is probably going to
7 object to some of the questions that I ask.
8 Unless he specifically instructs you not to
9 answer the question, once he finishes his
10 objection, you will need to go ahead and
11 answer the question.

12 A. Yes.

13 Q. Does that make sense? Okay. The court
14 reporter administered the oath to you a
15 moment ago. You assented to that meaning you
16 are under oath for the entirety of this
17 deposition. It's the same as if you were
18 testifying under oath in a courtroom, which
19 means you must testify -- excuse me, testify
20 truthfully.

21 Do you understand?

22 A. Yes.

23 Q. All right. Is there any reason you cannot
24 testify truthfully today?

25 A. No.

1 Q. And if you recall additional information
2 responsive to any of my questions later on in
3 the deposition, please just let me know and
4 we can go over it, all right?

5 A. Okay.

6 Q. Okay. So what did you do to -- if anything,
7 to prepare for this deposition today?

8 A. I rereviewed some materials that I had
9 already reviewed prior just to refresh my
10 recollection. The materials included the
11 materials that I listed in my report
12 including medical records; the deposition; my
13 own -- my own report; and, oh, Dr. Ettner's
14 declarations.

15 Q. Did you bring any documents with you today?

16 A. I have a copy of my own report that was
17 submitted.

18 Q. Anything else?

19 A. Not with me, no.

20 Q. Okay. Have you ever been sued before?

21 A. No.

22 Q. Other than expert witness work, have you ever
23 been involved in other lawsuits?

24 A. No.

25 Q. Okay. All right. So I'm going to go ahead

1 and give you an exhibit which we'll mark as
2 Exhibit 1, please.

3 (BOYD EXHIBIT 1, Curriculum Vitae, was
4 marked for identification.)

5 BY MR. SIEGEL:

6 Q. You'll see that this is your résumé or your
7 CV --

8 A. Thank you.

9 Q. -- that you provided earlier in this case.
10 Would you please just take a look at it and
11 let me know if this is up to date.

12 A. I think there are -- so there have been two
13 updates to this, both of which are
14 publications, that I'm not seeing here. One
15 is the book chapter which I think you --
16 which is, I think, going to be in press in
17 September.

18 Q. Okay.

19 A. And the other is a -- a journal article about
20 threat assessment that doesn't have anything
21 to do with trans folks --

22 Q. Okay.

23 A. -- or correctional settings specifically.

24 Q. All right.

25 A. Those are the only two things that I can

1 see --

2 Q. Okay.

3 A. -- are -- are updated.

4 Q. All right. Thank you. Could you just walk
5 me through your educational background.

6 A. Certainly. I have a bachelor's degree in
7 psychology from the University of Illinois.
8 I have two master's degrees, one in
9 counseling psychology, one in clinical
10 psychology. I have a certi- -- graduate
11 certificate in developmental disabilities. I
12 have a Ph.D. in clinical psychology from the
13 University of Kentucky. I did a -- a
14 postdoctoral fellowship in forensic
15 psychology at the University of Virginia and
16 I'm board-certified as a forensic
17 psychologist with the American Academy of
18 Professional -- sorry, American Academy of
19 Professional Psychology.

20 Q. Okay. In your academic studies, did you have
21 any particular focus on any particular
22 subject matter?

23 A. Early on. So the -- the focus was primarily
24 on folks with developmental disabilities and
25 interpersonal trauma so primarily sexual and

1 domestic violence work. That was mostly in a
2 treatment capacity and I was also a direct
3 service provider, like a caregiver kind of
4 role. Then in graduate school in the course
5 of my first master's program, I started doing
6 more forensic work specifically on the victim
7 side in criminal cases and then I shifted to
8 a forensic focus. So midway through my first
9 master's degree was when I shifted to a
10 primarily forensic focus.

11 And then when I completed my Ph.D., my
12 dissertation and my master's were both about
13 intellectual disabilities and personality
14 functioning. So those were the two areas was
15 personality and -- and intellectual
16 developmental disabilities, but I started
17 completing my forensic training in earnest
18 around the end of my Ph.D. when I was doing
19 training rotations in psychiatric units in
20 forensic hospitals. Excuse me. And then I
21 did forensic training in New York as part of
22 my predoctoral fellowship. The postdoctoral
23 fellowship was entirely forensic. It's not
24 required, but it's something that I did in
25 part to make sure that I had a sufficient

1 depth and breadth of knowledge to practice
2 competently as a forensic evaluator partly
3 because my early focus had not been forensic.
4 And since then, you know, I also completed
5 the board certification, again, to bolster my
6 knowledge in terms of the forensic area.

7 So in recent years, it's been
8 primarily -- well, I'm exclusively forensic
9 in my practice. Most of my work focuses
10 on -- sexual/gender minority populations,
11 intellectual developmental disabilities, and
12 interpersonal trauma I would say are the --
13 kind of the three big areas.

14 Q. Okay. And this is perhaps a dumb question,
15 but can you just define forensic for me.

16 A. Yeah. So forensic in -- in -- in psychology,
17 it means the application of psychological
18 science to help triers of fact answer
19 questions related to legal or quasi legal
20 matters. So it's not always actually a --
21 like a criminal or civil context. It could
22 be an administrative proceeding or something
23 like that as well.

24 Q. Okay. In your studies, did they involve
25 anything with transgender individuals or

1 gender dysphoria?

2 A. Yes. So when I was in my counseling
3 psychology program, one of my professors had
4 a specific interest in the fluidity of both
5 sexuality and gender over life span and so I
6 had a gender development coursework, which
7 is, you know, really kind of the framework
8 that a lot of us think within now as a gender
9 development kind of mind set about these
10 things.

11 Additionally, I -- when I was on my
12 forensic postdoctoral training at UVA, my
13 colleague was somebody -- Eugene Simopoulos,
14 who published extensively and was doing
15 evaluations for -- they were independent
16 evaluations for incarcerated transgender
17 folks in the Virginia DOC. So they would
18 hire independent psychologists to come in and
19 do an evaluation and that is when I actually
20 became -- became involved in doing
21 evaluations of folks where it wasn't, like,
22 incidental, right. It -- before that, I had
23 certainly encountered transgender and gender
24 diverse folks where that wasn't the central
25 question; that was just part of the -- their

1 identity when they came in for a competency
2 evaluation or something like that, but that's
3 when we began to -- I began to focus more on
4 doing the evaluations that are focused
5 specifically on gender. Around that time,
6 you know, he was also publishing some papers
7 in that regard. I did not publish with him,
8 but I was certainly reading up on it. We
9 also have another individual in our area,
10 Michael Hendricks, who assisted in writing
11 the APA's gender treatment-related guidance
12 from 2015.

13 So I had the professional associations
14 with those folks and that's when I began
15 doing more of the evaluations that were
16 really -- where the question related to
17 the -- to somebody's gender and what they
18 wanted to do in terms of treatment.

19 Q. And what year was that when you started doing
20 these evaluations?

21 A. When I started doing the evaluations on
22 incarcerated people, specific to issues
23 related to gender would have been around, I
24 think, 2013.

25 Q. Okay. And that was part of your fellowship;

1 is that right?

2 A. Yes.

3 Q. Okay. And you said you were doing gender
4 dysphoria evaluations, I -- I think?

5 A. Yeah. So it's interesting. The referral
6 questionnaire wasn't very clear a lot of the
7 time. It was just, we need an independent
8 evaluation of this person. And I noticed
9 that some of the evaluators were treating the
10 evaluation as a question of whether or not
11 the individual was, in fact, transgender and
12 that, in my view, is not an appropriate
13 question for that evaluation. It was more
14 what does this person need and do they need
15 support.

16 So the evaluations that I wrote were
17 different from my colleagues. I -- I don't
18 want to make it seem like I just, you know,
19 learned from their type of practice and
20 adopted that. I started doing things
21 slightly differently around that time, but I
22 was doing my own independent evaluations
23 through the Virginia Department of
24 Corrections where they would contact me to do
25 those independent evaluations. And

1 typically, I did make recommendations about
2 what kind of intervention I thought the
3 person ought to receive, but typically, it
4 was, you know, more looking at did the person
5 have issues with literacy or their cognitive
6 functioning or something like that where they
7 just might need help in understanding what
8 their options were.

9 Q. What kinds of interventions would you
10 recommend?

11 A. Most of the people that I was getting
12 referrals for were very early in terms of --
13 they were not seeking very difficult kinds of
14 modifications. They wanted things like
15 access to boxer briefs or certain kinds of
16 deodorant so essentially cosmetic items.
17 There were some people who wanted to have --
18 ultimately described wanting to have surgical
19 procedures, access to hormone treatment --
20 endocrine management, I should say, and for
21 most of those folks, the question for me was
22 not should they have those things. It was
23 just, you know, do they understand, do they
24 have the capacity to -- to reason about those
25 things and do they need support.

1 So, for example, one person did have an
2 intellectual disability, very low IQ and very
3 limited literacy, and all that person wanted
4 was the cosmetic kind of -- and -- and
5 garments, really. So that was a very easy
6 one, you know, to say, well, this person is
7 going to need -- if they do want to do more
8 difficult interventions, they're probably
9 going to need more support and don't just
10 give them a written handout because they
11 can't read. So it wasn't saying they
12 shouldn't get those things and my
13 understanding is they ultimately did get
14 those things. But the -- the issue was more
15 how could this person be accommodated given
16 their impairments so that they could continue
17 to move through that process to seek whatever
18 accommodations they felt were appropriate and
19 good for them.

20 Q. Okay. Is there anything else about your
21 educational background that you think is just
22 important to know for, you know,
23 understanding your career?

24 A. If you'll give me a moment to just glance
25 through my own CV to --

1 Q. Sure.

2 A. -- refresh my recollection. I want to make
3 sure I'm thorough. So the only other thing
4 that's potentially relevant related to my
5 educational history is that I was one of the
6 founding member -- members of our graduate
7 school -- what they ended up calling a
8 diversity committee. And my role
9 specifically on that panel was to be a
10 graduate student representative and my
11 particular area of diversity that they asked
12 me to offer input about was related to LGB
13 key -- LGBTQAI [sic] or what we call sexual
14 gender minority issues for that panel. So in
15 that regard, I was advising my own graduate
16 program of how they might do a better job of
17 not just providing training to graduate
18 students but also recruiting sexual and
19 gender minority graduate students to
20 ultimately become students and practitioners.

21 Q. Got it. Anything else?

22 A. No.

23 Q. Okay. I'd like to turn to -- there's a lot
24 here. Where is it? -- your publications,
25 which is on Page 7.

1 A. Yes.

2 Q. There's a -- a lot here so no need to take
3 you through all of them. My question is, do
4 any of the publications listed here concern
5 gender dysphoria?

6 A. I do not believe so.

7 Q. Okay. And please take a moment --

8 A. Yes.

9 Q. -- if you'd like.

10 A. No, I do not believe so.

11 Q. Okay. You did reference you have a -- you're
12 a coauthor of a book chapter.

13 A. Yes.

14 Q. And I believe it's concerning Psychological
15 Evaluation, Management, and Treatment of
16 Transgender and Gender Diverse People in --
17 Housed in Correctional Settings; is that
18 right?

19 A. Yes.

20 Q. Okay. Can you just tell me about what the --
21 what -- what is this book chapter?

22 A. Yeah. Yeah. So I was invited to coauthor
23 this book chapter. The author -- the other
24 authors include Walter Campbell, who is a
25 correctional psychologist in Idaho; Sarah

1 Miller, who's a forensic psychologist who
2 works for the State in Maine; Christy
3 Olezeski, who is one of the psychologists at
4 the Yale Pediatric Gender Clinic; excuse me,
5 and Dee Farmer of Farmer v. Brennan, who --
6 we all coauthored this book chapter and the
7 book chapter is written specifically for
8 forensic psychologists who practice either --
9 you're either employed in a correctional
10 setting like a prison or you provide services
11 to folks in those settings. And so the book
12 chapter is part of a -- a manual -- sorry, a
13 textbook, I should say, about correctional
14 mental health care. Ours is really -- so the
15 entire book is not about transgender folks;
16 it's a correctional textbook.

17 Q. Uh-huh.

18 A. Our chapter is the one that's about providing
19 assessment and treatment to transgender folks
20 who are in correctional settings. So we
21 collaboratively wrote this chapter and it
22 provides a little bit of background, but it
23 mostly talks about ethical practice, areas of
24 competency to develop, and, you know,
25 considerations related to things like gender

1 testing norms and things like that.

2 So that's the book chapter. It is
3 currently in sort of the final stages of -- I
4 think we just sent in some of our last
5 proofs, but I don't have the final, you know,
6 PDF version of the chapter that will be
7 published yet. However, my understanding is
8 that they anticipate it will be published in
9 September.

10 Q. Okay. And what's the name of the book that
11 this is going to be in?

12 A. I do not remember the name of the actual
13 book. I --

14 Q. Okay.

15 A. -- only remember our book chapter, which is,
16 Incarcerated While Transgender.

17 Q. Okay. Was there a specific part of the
18 chapter that you were responsible for
19 drafting?

20 A. Yes. So I helped to write the parts about
21 informed consent. I helped to write the
22 parts about -- I primarily wrote the sections
23 about informed consent. I don't want to make
24 it sound like I entirely did it because we
25 all edited each other's pieces. But I was

1 focused on the sections about informed
2 consent, about cooccurring mental health
3 conditions, and about -- a little bit about
4 the minority stress issues in prison, and
5 some of the testing and ethical
6 considerations.

7 Q. Okay. Does the book chapter address
8 evaluating transgender people with gender
9 dysphoria for surgery?

10 A. Yes, as part of an interdisciplinary team.

11 Q. Okay. What does it say about that subject?

12 A. Well, so there's a lot that we say about it.
13 So one of the things we talk about are the
14 ethical issues with gatekeeping with the
15 psychologist being the person who's in a role
16 of saying this person should or should not
17 have access to treatment. And so in our book
18 chapter we take the position that that's not
19 an appropriate role for a psychologist to
20 take not because we believe other
21 professionals are the ones who should be
22 making that determination but because we
23 believe that most trans folks are the experts
24 on what they feel that would make them feel
25 best as a -- as a starting point to that

1 process. So we did discuss that.

2 The testing part is really about, you
3 know, that -- that's a challenging area so
4 would probably be difficult to describe in
5 brief, but about the importance of knowing
6 the limitations of the current testing that
7 we have available but also the utility of
8 using testing and how we might offer caveats
9 about it. So those are the sections that,
10 you know, off the top of my head I recall I
11 was primarily -- the primary author for.

12 Q. Okay. Does the book chapter address
13 evaluating medical necessity for surgery?

14 A. Very briefly. Not in a lot of detail at all
15 because none of us were medical doctors
16 authoring the book chapter. Dr. Olezeski is
17 part of an interdisciplinary team at the Yale
18 Pediatric Gender Clinic and so in her -- in
19 her group there's -- you know, there's her
20 and then there's pediatrician
21 endocrinologists so they collaboratively
22 approach that and that was her input.

23 Q. Okay. And -- and what -- what is the input,
24 if you remember?

25 A. Essentially, you know, that the -- the

1 medical aspects are best for the medical
2 folks to make determinations about and have
3 discussions with folks about but that the
4 medical aspect of informed consent, for
5 example, is not the only piece of informed
6 consent that's important.

7 Q. Is there anything in the book chapter --
8 excuse me, book chapter about evaluating
9 whether any treatment, including surgery,
10 would be psychologically necessary?

11 A. I don't know that we used the word necessary
12 so much as the word beneficial. So we did
13 talk about that intervention is often
14 beneficial for trans people. Obviously, it
15 has to be tailored and individualized, but I
16 think the fundamental, you know, gist of the
17 chapter is that as psychologists, in fact, we
18 should be advocates for trans folks receiving
19 treatment that's appropriate for them, but
20 part of that also means we're -- we're
21 usually referring to kind of broader advocacy
22 within our organizations, not advocating on
23 behalf of -- behalf of one particular
24 individual just -- just because they're trans
25 but, rather, saying we need to do a good job

1 with our institutional culture of teaching
2 more about how to effectively treat and work
3 with folks who are sexual and gender
4 minority.

5 Q. So the chapter is focused exclusively on
6 incarcerated people; is that right?

7 A. Well, yes. I think there may be readers who
8 are involved in parole or probation kind of
9 supervision, but that's not the primary
10 audience for the book.

11 Q. Understood. So does -- in your view does the
12 psychological evaluation of transgender
13 people in a carceral setting -- is that
14 different from the evaluation of -- of
15 transgender people in a community setting?

16 A. Yes.

17 Q. How so?

18 A. Well, for one thing, there are a number of
19 constraints that are present in the carceral
20 setting and there's also a lot of points of
21 possible intervention starting from
22 sentencing before the person even enters that
23 particular setting. There are a lot of ways
24 in which the individual trans person doesn't
25 have the kinds of choices in a carceral

1 setting that they would have in the
2 community. That also includes access to
3 social support where -- the way that most
4 prisons are set up even geographically makes
5 it very difficult for people to have contact
6 with their family members. So there are
7 aspects of the prison setting that are unique
8 and there are ways in which our opportunities
9 as psychologists are constrained as well
10 compared to community-based treatment.

11 There are also differences, too, in that
12 in the community, there isn't necessarily a
13 right to medical treatment the way that there
14 is in a prison. And so that is also a
15 significantly different sort of configuration
16 of how we might think about accessing mental
17 health care. There are many, many people in
18 the community who I'm sure wish they also had
19 the right to access medical and mental health
20 care, but the reality is that the way that
21 when we're looking at practicing, the
22 correctional setting is the one where people
23 are supposed to get it.

24 Q. And what is your understanding of the -- the
25 right to receive healthcare in prison?

1 A. My understanding of it is based on my
2 forensic training so it's not a legal
3 understanding; it's --

4 Q. Sure.

5 A. -- a forensic psychological understanding.
6 But most of the time, what we talk about is
7 the Estelle v. Gamble case and the idea that
8 because people have been dep- -- if someone
9 has been deprived of their liberty and
10 they're in a carceral setting, then that is
11 what creates the obligation to provide
12 medical care to them.

13 Q. You talked about -- you used the term
14 psychologically beneficial; is that right?

15 A. Right.

16 Q. Does -- can someone's carceral status affect
17 whether any given treatment would be
18 psychologically beneficial?

19 A. Yes.

20 Q. How so?

21 A. For example, with post-traumatic stress
22 disorder, one of the things that a lot of
23 people don't realize about post-traumatic
24 stress disorder is that the first step in
25 treating PTSD is achieving safety for the

1 person, not actual treatment or what most
2 people would think of as treatment. In
3 carceral settings it actually pays to be
4 hypervigilant. It is important for your
5 safety to monitor your environment for
6 threats. Depending on the type of setting
7 that you're in, other people may have
8 incentives to mistreat you or try to gather
9 information from you or something like that.
10 So these are generally much higher-stress
11 settings for most people compared to a
12 community-based environment and certainly,
13 that's one thing that -- I'm just giving PTSD
14 as an example.

15 Another issue can be if you have a
16 condition like schizophrenia. There are a
17 lot of options for treatment in the community
18 that are typically not available in the
19 carceral setting for a variety of reasons.
20 Some of the medications that people take
21 require frequent blood work and -- to make
22 sure they're not getting poisoned or that
23 their, you know, white blood cell count isn't
24 out of whack or something like that.

25 So there are treatments for medical --

1 or, sorry, psychological conditions that
2 are -- we have to adapt or sometimes they're
3 just completely unavailable in carceral
4 settings for a variety of reasons.

5 Q. Does the unavailability of a treatment or
6 intervention mean that it -- it -- it
7 wouldn't be psychologically beneficial or
8 does it just mean for -- like, for practical
9 reasons, you can't do it?

10 MR. RODRIGUEZ: Objection to form. You
11 can answer.

12 A. Do you mind re- -- repeating the question?

13 Q. Sure. So -- see if I can remember what I
14 said. In -- so if you have a -- one of these
15 treatments or interventions and if -- if it's
16 not available, were -- did you mean to say
17 that that treatment wouldn't have a
18 psychological benefit for someone or simply
19 it just isn't available for practical
20 reasons?

21 A. So that's a good question and the PTSD is a
22 pretty good example for that one. So they do
23 have PTSD treatment in prisons including in
24 the federal prison system. However, you
25 know, as I said, the first step in PTSD

1 treatment is actually ensuring that the
2 individual is safe. And so you can -- you
3 can deliver interventions that might -- might
4 benefit -- that same intervention might
5 benefit that individual in the community if
6 they were safe and if they didn't have the
7 stressors associated with the carceral
8 environment where the exact same individual
9 and the exact same treatment produces a far
10 greater benefit because of the fact that when
11 they're in the carceral system, they have
12 factors that are actually actively
13 maintaining their illness because of the
14 stress and the threat of the environment,
15 even the social context of it. So even for
16 the same individual, they might get a
17 different benefit in the community versus a
18 carceral setting with the exact same
19 treatment.

20 Q. Is there any health condition you can think
21 of where the -- the benefit to the patient
22 would be maximized in a carceral set- --
23 excuse me, a carceral setting as opposed to a
24 community setting?

25 A. I can't comment on medical conditions, but I

1 can say for mental health conditions --

2 Q. Uh-huh.

3 A. -- that's a difficult question because of the
4 fact that there are some people who will only
5 get care while they're incarcerated because
6 of the fact that they're so poor and they're
7 so limited in terms of their access in the
8 community. I've certainly seen people where
9 I -- I frankly had anxiety about their
10 release because my concern was that they were
11 going to get no care in the community.
12 However, I can't think of a -- you know,
13 offhand of a psychological condition where I
14 would say that that's true.

15 Q. Okay. And so getting back to gender
16 dysphoria, is there any gender-affirming
17 treatment or intervention where a patient
18 would not receive psychological benefit
19 simply because they are incarcerated?

20 A. I don't think there's enough information for
21 me to answer that question. Like, it's -- it
22 would depend so much on the circumstance it's
23 hard for me to come up with an example of
24 one.

25 Q. Okay. Well, just -- I mean, the fact of

1 incarceration itself --

2 A. Uh-huh.

3 Q. Can the fact of incarceration itself mean
4 that a treatment will have no psychological
5 benefit to a patient?

6 MR. RODRIGUEZ: Object as speculation.
7 You can answer.

8 A. I think there are situations where it would
9 be less. I don't -- I'd have to -- I'm not
10 sure if there would be a situation where I
11 would say there would be none. I think it's
12 possible that that would -- would be, but it
13 would depend very much on the person's
14 circumstances. So if they were in solitary
15 confinement or double solitary, for example,
16 and you're trying to give them a mental
17 health treatment, it's -- you know, or -- or
18 a treatment for something related to gender
19 dysphoria but they're in double solitary with
20 someone who's acutely transphobic, yeah, I
21 could absolutely see that almost no matter
22 what you did to help that person, unless you
23 resolved that issue, they're going to
24 continue to be acutely distressed.

25 Q. Okay. Anything -- we've gotten off track a

1 little bit. Anything about the book chapter
2 that we haven't spoken about that you think
3 is interesting or that you're proud of?

4 A. Well, one thing we are working on doing is
5 making the book available to folks -- we want
6 to make sure the book chapter is available to
7 incarcerated folks themselves and not just
8 the professionals. So one of the things that
9 we are working on is making sure that not
10 just the book is available in prison
11 libraries for use by incarcerated people, but
12 we're also working on a version of our
13 chapter that will be available for folks who
14 have significantly limited literacy so
15 essentially like a multimedia presentation of
16 the chapter content so that incarcerated
17 tran- -- transgender folks themselves can
18 access all the information in our chapter.

19 Q. I think that's great. Not a -- that's a
20 comment, not a question.

21 All right. Changing gears a little bit,
22 let's flip to your teaching and training
23 experience. Sorry. Having trouble finding
24 it.

25 A. Page 8.

1 Q. Thank you. There we go. Okay. So I want to
2 ask you about the first item listed,
3 Conducting forensic mental health evaluations
4 with individuals who are transgender or
5 gender nonconforming.

6 Did I read that right?

7 A. Yes.

8 Q. Okay. What -- is this a -- a training that
9 you did?

10 A. Yes, through the University of Virginia.

11 Q. Okay. What did the training involve?

12 A. So there were multiple presenters. I'd have
13 to re- -- I'd have to go back and look to see
14 the names of everybody, but Dr. Olezeski was
15 one of them who coauthored the book chapter
16 and we had a panel discussion as well. And
17 so the description in my CV is pretty
18 accurate about, you know, what the
19 considerations are for folks who are trans or
20 gender nonconforming in -- we say criminal
21 justice context, not correctional, because we
22 are also talking about evaluations that might
23 be conducted on folks who are in the
24 community, not presently in custody. The
25 ethical considerations, we were talking about

1 things like gatekeeping, about not dead
2 naming and things like that that could be
3 harmful to the person. Example language and
4 queries for taking a gender development
5 history, so that was basically how to query
6 these things in a respectful way and really
7 to some extent it was etiquette. The case
8 law was covered by another presenter. And
9 referral considerations, those were
10 primarily, like, medical referral
11 considerations. At that time, we were still
12 under WPATH Standards of Care 7 where there
13 were requirements for -- more requirements in
14 terms of written letters and that sort of
15 thing so we also addressed the -- that is
16 what we're talking about when we're talking
17 about referral considerations.

18 Q. You mentioned the -- the WPATH standards.
19 What did you mean -- I think you said you
20 were under the WPATH standards. What --

21 A. Oh, the -- yeah.

22 Q. What -- what --

23 A. The new ones had not been published yet so in
24 terms of -- I have -- I don't endorse the
25 WPATH standards, the 7 -- the Version 7.

1 That's why I'm not a member of WPATH and have
2 not been historically. However, in terms of
3 the actual practice that you see most
4 psychologists having to engage in, if a
5 transgender comes into your office and they
6 say, I need a letter, usually what they mean
7 is, I'm in the process of getting the -- you
8 know, contacted an agency or an organization.
9 They've indicated, I need this letter so I'm
10 coming to you to get a letter.

11 And so most of the time, what's
12 happening is that the people who are actually
13 going to be providing the medical care to
14 them are operating under the WPATH standards
15 of care and require two letters then from
16 medical professionals. And so we had to --
17 that -- you know, that was the understanding
18 and that's what you comply with. Whether you
19 agreed with that provision or not, you knew
20 that their medical care providers were going
21 to require that.

22 Q. Okay. So I know that you don't endorse
23 WPATH. I'll get to that in a moment. Did
24 you say that most providers en- -- endorse it
25 or follow it? I can't remember exactly what

1 you said.

2 A. I would say that most of the medical care
3 providers that I -- that I've worked with are
4 utilizing those standards in terms of how
5 they determine somebody's appropriateness and
6 what kind of hoops they should have to jump
7 through before they can have --

8 Q. Uh-huh.

9 A. -- what they want. I would say that's --
10 it's an -- like an informal organizing kind
11 of set of expectations for us as
12 psychologists is that that's -- what we're
13 going to do is what WPATH suggests we do in
14 terms of providing letters and the
15 requirements his- -- the historical
16 requirements that the person have socially
17 transitioned for a period of time before
18 they're allowed to have those interventions
19 and so forth. And so it was mostly that we
20 ex- -- we believed that -- that the medical
21 professionals were going to expect that of us
22 in order to agree to do the procedures for
23 the person or prescribe medication.

24 Q. Okay. Are -- do you have, like, a wholesale
25 rejection of the WPATH standards or are there

1 specific parts of it that you disagree with?
2 A. The newer version that just came out, I think
3 there are significant improvements there. My
4 primary concern with WPATH is that it's
5 predicated on a -- what I view as a
6 binary-oriented medical essentialist model
7 and I don't think there's an -- that WPATH
8 has created enough room for nonbinary people
9 or people whose gender may be not -- people
10 who may not necessarily need or want surgical
11 procedures or hormonal intervention. I also
12 think that most of this treatment has to be
13 highly individualized for the person. And I
14 think WPATH describes themselves as these are
15 flexible guidelines, you know, not a -- set
16 in stone. But that's -- yeah, that would be
17 my response to that question.

18 Q. Okay. So when it comes to the WPATH standard
19 for, let's say, evaluating someone for --
20 evaluating someone and referring them for
21 hormone therapy, what do you think of what
22 WPATH says?

23 A. I think that most folks are able to make that
24 decision. You know, my issue with it was
25 that I didn't believe that somebody should

1 have to have transitioned socially for a
2 period of time before they're permitted to
3 access hormonal intervention or surgery.

4 Q. Uh-huh.

5 A. That's really my primary issue with it. I
6 also don't think they should have to have so
7 many letters from psychologists probably.

8 Q. Okay.

9 A. And that was my historical objection to WPATH
10 was really more about the ways in which I
11 felt that they actually prevented trans and
12 gender-nonconforming folks from receiving
13 care rather than facilitating it because my
14 view is WPATH has a -- like I said, a narrow
15 medical essentialist model historically,
16 although I do see an improvement in the
17 eighth version of the standards of care.

18 Q. Okay. So summing up, do you -- you think
19 the -- the seventh standards are too
20 restrictive with respect to you referring
21 someone for gender-affirming care?

22 A. Yes. I think there were a number of people
23 that were probably held back from receiving
24 care that they needed because those standards
25 were excessively restrictive.

1 Q. Okay. All right. Back to your CV. I'm
2 looking at the third item down in your
3 teaching and training experience --

4 A. Yes.

5 Q. -- University of Virginia health services
6 panelist: How experience might inform
7 ethical practice, et -- et cetera.

8 What -- what did this involve?

9 A. This was a training that was set up by Janet
10 Warren, who was our training director at the
11 time. The original focus that she wanted to
12 have was on girls in the criminal justice
13 system, but we wanted to expand that model
14 for basically gender minority folks as well.
15 We ended up having a panel. It was myself,
16 Christy Olezeski, and then I think it was
17 Dallas -- I'm blanking on her last name.
18 She's actually fairly well known. I just
19 can't remember her last name for some reason,
20 but she is a service provider. And so we
21 were answering questions after folks had
22 participated in a training on that topic. So
23 I wasn't involved in the training that
24 preceded that; I was involved in the -- just
25 the panel so just answering questions from

1 the audience.

2 Q. Okay. Did this training have anything to do
3 with evaluating gender dysphoric patients for
4 gender-affirming care?

5 A. Yes. You know, like, for example, one of the
6 questions that we got was, you know, does
7 trauma cause somebody to be transgender? Is
8 that something that needs to be resolved
9 before somebody can get care? So those were
10 the kinds of questions that the attendees
11 had. It was that kind of -- it was just
12 being available to answer questions. But
13 I -- the questions that they asked were
14 pretty revealing of what the issues were with
15 the attendees --

16 Q. Uh-huh.

17 A. -- I think, too.

18 Q. Uh-huh. Was surgery addressed?

19 A. That actually did not come up much at that
20 panel discussion, which is -- you know, we
21 were focused on younger kids at that -- you
22 know, adolescents at that time.

23 Q. Okay. Did any of the other entries under
24 your teaching and training experience concern
25 gender dysphoria?

1 A. I think on Page 11 there's the Migrant
2 Network Coalition workshop coleader. So at
3 this point in Lexington, they were
4 considering some very restrictive
5 anti-immigrant policies and we developed this
6 workshop to talk about issues with folks who
7 were sexual gender minority but also who had
8 cooccurring disabilities and were potentially
9 undocumented or -- or had other concerns
10 about their immigration status and how
11 aggressive anti-immigrant policies would
12 actually cause those people to be more likely
13 to be victims of crimes.

14 Q. Anything else?

15 A. Not -- I will tell you I do not recall if
16 Project Safe, which was the project related
17 to trying to promote excessive bil- --
18 disability accessibility from rape crisis and
19 domestic violence agencies -- I don't recall
20 if that included discussion of sexual and
21 gender minority folks who are transgender or
22 not.

23 Q. Okay. All right. Well, if that's everything
24 there, let's turn to -- let's see -- your
25 presentations. Once again, missed it. I

1 know it's in here somewhere.

2 A. Page 12.

3 Q. Thank you. All right. So in these
4 presentations, did any of these concern
5 transgender people or people with gender
6 dysphoria?

7 A. Yes. In fact, one of them I'm very proud of.

8 Q. Which one is that?

9 A. Yes. So the second entry, Boyd, Barretto,
10 and Zelle -- so this was myself, a
11 psychologist who is a J.D./Ph.D. and who
12 specializes in advanced directives for
13 Virginia and then another -- a -- a
14 transgender woman who had had some -- was,
15 you know, openly disclosing that she had had
16 some post-traumatic stress disorder. And so
17 what we did was we created an advanced
18 directive for her and the whole point -- we
19 presented at the Philadelphia Trans Health
20 Conference that year and the point of it was
21 that, look, you can use an advanced directive
22 as a transgender person to communicate with,
23 like, for example, local hospitals about how
24 you want to be treated if you're
25 incapacitated. So if you get in a car

1 accident, you have a mental health episode,
2 something happens and you go to the hospital,
3 you can specify in advance, here's how I want
4 my hormone therapy to be maintained, here's
5 who I want to visit or who I do not want to
6 be allowed to visit, here's how I feel about
7 the use of restraints or seclusion
8 techniques. You can use all of that and you
9 can communicate in advance to help to protect
10 your rights and to document what your -- you
11 know, what your needs were in advance of, you
12 know, God forbid, an incapacitation.

13 So we developed an example one for my
14 copresenter and then we presented it at the
15 conference to -- to demonstrate primarily for
16 trans and gender-nonconforming folks about
17 how they can utilize advanced directives to
18 protect their rights in the event of
19 incapacitation.

20 Q. Do you know if it's been used any time since
21 for -- by other folks?

22 A. I do not know. I -- I know we developed one
23 for -- you know, what we did partly was we
24 talked about how to do it and then we
25 presented the example one that we did --

1 Q. Uh-huh.

2 A. -- for my -- for my colleague. I'm -- I'm
3 hoping that other people are using it and
4 Dr. Zelle is still very much involved in
5 advanced directive work and is, I believe,
6 spreading the good word about it.

7 Q. Any of these other presentations, did they
8 concern gender dysphoria or transgender
9 people?

10 A. No.

11 Q. Okay. Then in that case, let's turn to your
12 professional community service, which I'm
13 sure you'll beat me to again. That's on Page
14 5.

15 A. Oh, you know -- all right. Yes.

16 Q. All right. In your professional community
17 service, have -- have you had any particular
18 focus?

19 A. It's primarily been related to, you know, as
20 I mentioned earlier, my three primary areas,
21 which is sexual/gender minority populations,
22 intellectual and developmental disabilities,
23 and interpersonal violence. So the diversity
24 committee founding member thing is what we
25 talked about before as a graduate student

1 representative and then the others relate to
2 intellectual and developmental disabilities
3 primarily.

4 Q. Okay. And in these activities do you ever
5 perform mental health evaluations?

6 A. Oh, no. These -- no. These were, like,
7 advisory panels --

8 Q. Okay.

9 A. -- basically.

10 Q. That being said, is there anything here that
11 you're parti- -- particularly proud of or
12 that you think is just important for
13 understanding your career?

14 A. Well, it's more of a big picture thing,
15 but --

16 Q. Uh-huh.

17 A. -- you know, one of the things that you
18 probably see throughout this is that the
19 disability aspect is quite a strong component
20 of my training and I would say that
21 disability is sort of -- that framework is
22 the organizing set of principles around a lot
23 of what I do.

24 So, for example, you'll notice there's
25 no publications that I have or presentations

1 that I have about trans folks that don't
2 involve a coauthor -- another coauthor who is
3 also trans or gender nonconforming and that
4 comes from -- in disability we talk about
5 nothing about us without us and that is a,
6 you know, important value that we have coming
7 from that community, but I think it organizes
8 a lot of my other work even when the focus is
9 not specifically on disability status.

10 Q. Okay. All right. I'm going to change gears
11 a little bit and hand you what we're calling
12 Number 2. It's just your expert report in
13 this case.

14 (BOYD EXHIBIT 2, Expert Report of Sara
15 E. Boyd, Ph.D., ABPP, was marked for
16 identification.)

17 BY MR. SIEGEL:

18 Q. All right. And I want to flip to the
19 appendix, which is a list of cases.

20 A. Yes.

21 Q. And that's where -- these are cases that you
22 provided --

23 A. Uh-huh.

24 Q. -- expert testimony in; is that right?

25 A. Yes.

1 Q. Over the last four years?

2 A. Yes.

3 Q. All right. So for the cases listed here, did
4 any involve a person with gender dysphoria?

5 A. Let me take a look. None of these do. I
6 believe the last case that I testified in
7 that involved a transgender individual was a
8 criminal case and I don't think it's on this
9 list because it only covers the last four
10 years.

11 Q. Okay. Do you remember the name of that case?

12 A. I believe the person's last name was Ernest.

13 Q. Okay.

14 A. They're deceased, unfortunately.

15 Q. Do you remember the jurisdiction it was in,
16 the court?

17 A. It was in Virginia. I don't believe it was
18 in one of the jurisdictions that I typically
19 testify in so not northern Virginia. I'd
20 have to go and look it up.

21 Q. Okay. Do you remember if it was State or
22 Federal Court?

23 A. It was State Court. It was a sentencing.

24 Q. And what was your involvement in that case?

25 A. This was an individual who had been convicted

1 of sex offenses and was up for sentencing.
2 She was a transgender woman who had a number
3 of mental -- significant mental health
4 problems. At the sentencing what I spoke
5 about primarily was my concern about her
6 well-being and safety in the carceral
7 environment and why I believe that ought to
8 be a mitigating factor in terms of her
9 sentencing and what considerations they might
10 undertake to keep her safe if she were to
11 serve a custodial sentence. The court did
12 not do what I suggested and she did
13 ultimately die by suicide.

14 Q. Any other cases not listed here that involved
15 a person with gender dysphoria or
16 gender-affirming treatment?

17 A. Well, I currently have, I think, three cases
18 right -- not counting this one, three cases
19 right now that involve folks with gender
20 dysphoria or who are transgender but not --
21 do not have gender dysphoria. I will say,
22 though, that most of the -- in most of those
23 cases, their gender identity is relevant but
24 not the central question so those aren't
25 cases where I've been asked to give any kind

1 of opinion about their, you know, informed
2 consent for a procedure or something like
3 that.

4 Q. Okay. In those cases has the court qualified
5 you as an expert in any of them?

6 A. Yes.

7 Q. Okay.

8 A. So in the sentencing I do not recall -- the
9 one that I just told you about, Ernest, I do
10 not recall it -- how I was qualified
11 specifically because it's usually either very
12 narrow or very broad. I don't recall if I
13 was qualified specifically as an expert in
14 transgender and gender-nonconforming folks in
15 that case or not. It would take me a minute
16 to think through past testimony regarding
17 other trans folks. I've never had to testify
18 in a case -- it just hasn't occurred.
19 They've always been resolved. -- involving a
20 incarcerated person where I was evaluating
21 them while they were incarcerated and then
22 giving an opinion about, for example,
23 informed consent-related issues.

24 Q. Okay. So in -- make sure I understand what
25 you're telling me. The -- in the cases --

1 you have three cases pending --

2 A. Yes.

3 Q. -- that involve a transgender person or
4 someone with gender dysphoria; is that right?

5 A. Well, they're either trans and they have
6 gender dysphoria or they're trans and they
7 don't have gender dysphoria.

8 Q. Okay. In any of those cases that -- that are
9 pending --

10 A. Uh-huh.

11 Q. -- has the court qualified you as an expert?

12 A. Oh, no. We haven't -- we're not to the point
13 of testifying in any of those.

14 Q. Okay.

15 A. And I haven't been appointed in any of them;
16 I was retained by counsel.

17 Q. Okay. Can you give me the names of those
18 cases?

19 A. I cannot because they're confidential mental
20 health cases. I could probably try to ask
21 the attorneys if I could disclose, but
22 because my work is in progress and I don't
23 even know if the other side has been notified
24 that I've been retained, it would potentially
25 be an issue for me to disclose that.

1 Q. Okay. Speaking generally without giving away
2 any confidential or sensitive information, do
3 those cases concern whether a person with
4 gender dysphoria should or should not receive
5 a certain treatment?

6 A. Yes. So -- but they're a little bit more
7 nuanced than, you know, is it, like,
8 gender-affirming treatment. It's usually a
9 broader look at what is their -- what are
10 their mental health needs generally speaking
11 and what do they need and for a lot of those
12 folks, that may or may not include a
13 component of, you know, gender-affirming
14 care.

15 Q. Okay.

16 MR. SIEGEL: All right. We've been
17 going for about an hour. I think now is
18 probably a decent time to take a short
19 break --

20 MR. RODRIGUEZ: Yeah.

21 MR. SIEGEL: -- if that works for you
22 all.

23 MR. RODRIGUEZ: Yeah.

24 (Whereupon, there was a recess in the
25 proceedings from 9:59 a.m. to 10:14 a.m.)

1 BY MR. SIEGEL:

2 Q. Back on the record. All right. Dr. Boyd,
3 welcome back. I just have a couple follow-up
4 questions from what we were just talking
5 about. Excuse me. I want to briefly revisit
6 the book chapter.

7 A. Uh-huh.

8 Q. Does the chapter discuss how prison
9 administrators or prison officials should
10 weigh an individual's determination that they
11 need a gender-affirming intervention in -- in
12 deciding whether to give them that
13 intervention?

14 MR. RODRIGUEZ: Objection to form. You
15 can answer.

16 A. We don't discuss sort of the administrative
17 decision-making in there, but we do note that
18 that's a factor that's present in that kind
19 of setting or administrative decision-making
20 and requirements that may not be present in
21 the community in terms of making a
22 distinction between care in prison and care
23 in the community.

24 Q. Okay. So there's nothing about how that
25 individual's self-determination affects

1 treatment decisions?

2 A. We do talk about that in the informed consent
3 discussion but not --

4 Q. Okay.

5 A. -- with respect to how administrative folks
6 should take that into account.

7 Q. Okay. And this is maybe -- you may -- may
8 have already addressed that, but how -- what
9 do you say about that in the informed consent
10 discussion?

11 A. I would have to have the chapter in front of
12 me to able to refresh my recollection. I
13 think it's more of a discussion about the
14 idea of taking a problem-solving approach
15 even internally as a psychologist.

16 Q. Okay. Earlier, you also mentioned that in
17 your view, WPATH is too restrictive; is that
18 correct?

19 A. Historically that it has been, yes.

20 Q. Okay. When you said it's historically too
21 restrictive, is that also in reference for
22 access to gender-affirming surgery?

23 A. The -- the issue with the restrictiveness is
24 more about, like, a general concern that it's
25 not a very culturally competent approach,

1 that there's assumptions that people have the
2 ability, for example, to socially transition
3 for a period of time before they can have
4 those kinds of procedures done. So that's
5 really more the critique --

6 Q. Okay.

7 A. -- whether it was hormones or surgery or some
8 other intervention.

9 THE WITNESS: My apologies.

10 BY MR. SIEGEL:

11 Q. All right. And with respect to your expert
12 testimony, you said that you had not had to
13 testify about -- or testify in a case
14 concerning someone with gender dysphoria; is
15 that right?

16 A. I've testified in cases that involve folks
17 who have gender dysphoria. I -- the question
18 that I've testified about has usually not
19 been whether or not they should have access
20 to treatment specific to gender-affirming
21 care. I have testified about access to
22 mental health treatment more broadly for
23 folks who happen to be trans, but the central
24 question wasn't related to their gender
25 identity.

1 Q. Okay. And so other than the cases that you
2 have pending, in the cases where you didn't
3 end up testifying, were you ever engaged to
4 write an expert report concerning
5 gender-affirming treatment?

6 A. Yes.

7 Q. Okay.

8 A. Yes. So typically, for the Department of
9 Corrections, for example, we would always
10 submit a report for that, but it's -- none of
11 those cases have gone to a point of any kind
12 of litigation where I've had to testify.

13 Q. Okay. Did you end up drafting a report in
14 those cases?

15 A. I believe in all of the ones for DOC, I've
16 always written a report.

17 Q. Okay. And did any of those cases where you
18 drafted a report -- did they concern
19 gender-affirming care?

20 A. Yes.

21 Q. Which ones?

22 A. For the -- I mean, all of the ones that I did
23 for the Virginia Department of Corrections
24 would have related to that, would have used
25 an informed consent approach, but it -- I

1 wouldn't have given an opinion about the
2 person should have this procedure or this
3 treatment. I would talk about barriers to
4 those things or problem-solving that might be
5 done if there was an issue, but it wasn't the
6 case that I would write a report that -- you
7 know, where the recommendation was, they
8 should have this medical treatment.

9 Q. Okay. Can you give an example of -- just
10 walk me through one of those cases and how
11 you got involved and what your process was
12 and what your report looked like.

13 A. So the director of medical services is
14 usually who makes the referral. They provide
15 me with information and authorization to
16 enter the facility. I meet with the
17 individual. I go through an informed consent
18 process with them to make sure they actually
19 want to participate in it because even though
20 the referral came from the facility, they're
21 not obligated to participate in the
22 evaluation. And then I would evaluate the
23 individual, meeting with them us- -- at least
24 once in person but often twice. I conducted
25 testing if it was necessary and then I would

1 draft a report.

2 So I gave you the example earlier of the
3 individual who their initial asks were just
4 related to basic cosmetic items, but what my
5 report ended up focusing on was just their
6 need for accommodations where they want -- if
7 they wanted to pursue, for example, endocrine
8 treatment because of their limited literacy
9 and cognitive ability. So that was more
10 talking about how we kind of remediate that
11 so that person can have treatment that they
12 want if they ultimately decide to pursue
13 that.

14 Q. Okay. And in the reports that you drafted,
15 did any of them concern gender-affirming
16 surgery?

17 A. I believe so, at least a couple of them, but
18 it -- most of the people that I've gotten
19 those referrals for have wanted lower-order
20 kinds of intervention in terms of the risk
21 profile. So it's usually been more of the
22 kind of physical, you know, clothing,
23 commissary items, or endocrine treatment as
24 opposed to surgery, although some -- at
25 lea- -- I think at least three individuals

1 did want surgery.

2 Q. Okay. Do you remember which cases those
3 were?

4 A. Not off the top of my head. I don't recall
5 the names, but they were not cases that I
6 testified in. As I said, I just wrote
7 reports.

8 Q. Uh-huh. And you were -- you were not engaged
9 by a private plaintiff for that; you were
10 appointed by the court; is that right?

11 A. Well, I was retained by the Virginia
12 Department of Corrections as --

13 Q. Okay.

14 A. -- an independent outside evaluator.

15 Q. Okay. And in these reports you didn't
16 provide a medical opinion --

17 A. Correct.

18 Q. -- right? Were you providing an opinion as
19 to whether surgery would be psychologically
20 beneficial?

21 A. I don't believe that for any of those folks I
22 did offer that opinion because, as I said,
23 even for the people who, I think, ultimately
24 wanted that, they were far earlier in the
25 process. They weren't asking for it yet.

1 Q. Uh-huh.

2 A. But they described a kind of process that
3 they anticipated going through ultimately
4 where surgery would be part of that picture
5 for them.

6 Q. And what surgeries were at issue in those
7 cases?

8 A. I -- it was, you know, what people call
9 bottom half surgery for most of those folks.
10 I don't recall anybody wanting to have -- who
11 was specifically seeking breast augmentation
12 or removal, you know, chest surgery. But,
13 yeah, I think it was all bottom half surgery.

14 Q. Okay. Any -- did any of those deal with
15 vulvoplasty or vaginoplasty?

16 A. Not vulvoplasty. That's less common than
17 vaginoplasty, but one person is a trans man
18 and I don't believe he was seeking bottom
19 half surgery. The three people who were were
20 all trans women.

21 Q. Okay. In any of those cases involving bottom
22 half surgery, did you -- did you conclude
23 that surgery would be psychologically
24 beneficial?

25 MR. RODRIGUEZ: Asked and answered.

1 You can answer.

2 A. No. I didn't give a medical opinion about,
3 you know, whether the -- well, I should
4 differentiate. There's a medical opinion
5 about whether or not the procedure itself
6 will likely be physically/medically
7 successful. The question of whether or not
8 it would provide them with psychological
9 relief, I believe I have offered the opinion
10 that endocrine intervention -- the things
11 that the person was asking for, that those
12 things were likely to confer a psychological
13 benefit. I don't recall evaluating anybody
14 who was at the point of asking for surgery
15 where I gave an opinion about that.

16 Q. Okay. All right. Let's turn then to your
17 clinical experience and employment. First of
18 all, is this -- is there any work in your
19 career that you found particularly
20 interesting and gratifying?

21 MR. RODRIGUEZ: Objection, vague. You
22 can answer.

23 A. Yeah. That is a big question.

24 Q. In your clinical experience and employment.

25 A. I mean, as I said, you know, my primary areas

1 of focus have been developmental
2 disabilities, interpersonal violence, and
3 then sexual/gender minority populations.
4 Those are the areas that -- the reason I
5 focus on those are because those are the
6 areas that I find more interesting and
7 rewarding.

8 Q. Okay. So I'm looking at the first page of
9 your expert report.

10 A. Yes.

11 Q. And I'm in the second sentence in the second
12 paragraph.

13 A. Yes.

14 Q. You write, As a psychologist specializing in
15 forensic mental health assessments, I have
16 conducted more than 100 evaluations of
17 incarcerated people housed in state and
18 federal prisons and jails. In particular, I
19 have conducted independent psychological
20 evaluations related to gender-affirming care
21 for incarcerated individuals.

22 Did I read all that correctly?

23 A. Yes.

24 Q. So how many evaluations related to
25 gender-affirming care have you done?

1 A. Spe- -- where that was specifically the
2 referral question, I think I would say
3 somewhere around 20 --

4 Q. 20? Okay.

5 A. -- to 25.

6 Q. And --

7 A. I should -- oh, I should be clear, too.
8 Those are folks that I know were transgender
9 so it's certainly possible I've evaluated
10 people who were trans that I just didn't know
11 that they were.

12 MR. RODRIGUEZ: Speak up.

13 A. That I just didn't know that they were trans.
14 Apologies.

15 Q. Okay. And -- and these 20 or so evaluations,
16 you were evaluating them related to whether
17 they needed gender-affirming care?

18 A. Yes.

19 Q. Okay. What does that mean?

20 A. In my report I describe that. So in that --
21 the sentence that says, In that ca- -- starts
22 with, In that --

23 Q. Uh-huh.

24 A. -- capacity, so there's the capacity to
25 provide informed consent part, which is

1 looking at do they have any conditions that
2 would impair their ability to understand the
3 information and make decisions.

4 To describe the nature and severity of
5 their gender dysphoria if present. So that's
6 typ- -- that was required by the Virginia DOC
7 that the person have a diagnosis of gender
8 dysphoria. So I would describe whether or
9 not they met criteria and, if so, what
10 symptoms they had.

11 To offer recommendations with respect to
12 gender-affirming interventions or building
13 capacity to provide informed consent. So,
14 for example, you know, I would have no
15 problem recommending that somebody receive
16 access to boxers if that's what they want or
17 something like that that's not a medical
18 intervention. So those kinds of things I
19 would often recommend. When I say, building
20 capacity to provide informed consent, I gave
21 an example of that earlier, the individual
22 where I said, don't just give them a handout
23 that they're supposed to read and understand.
24 And then the last part says, Identify any
25 cooccurring psychological disorders that may

1 require more active management or integration
2 into treatment planning for gender-affirming
3 interventions. So that's the detailed
4 description of what I did.

5 Q. Okay. I'd like to focus on the part where
6 you say part of your job is to offer
7 recommendations with respect to
8 gender-affirming interventions.

9 In any of these cases, did you offer
10 recommendations with respect to
11 gender-affirming surgery?

12 A. Not with regard to whether or not someone
13 ought to have it or not but, again, making
14 sure they understand. That -- that the
15 information is delivered to them in a way
16 that they can comprehend and understand would
17 be more of my consideration in that regard.

18 Q. So I'm not -- I'm trying to under- -- so --
19 beg your pardon.

20 So you're not offering a recommendation
21 in those cases that this patient needs or
22 doesn't need some kind of gender-affirming
23 surgery; is that right?

24 A. I would usually convey what the individual
25 told me about what they wanted and needed --

1 Q. Okay.

2 A. -- rather than necessarily saying, you know,
3 that I think they should have surgery.

4 Q. So then what kind of recommendations are you
5 offering?

6 A. So if the -- if the person has, for example,
7 other psychological disorders that are
8 cooccurring with it, then I might offer
9 recommendations about how -- if there's a
10 relationship between those things and the
11 gender dysphoria, for example, but it's not
12 going to be treated -- the cooccurring
13 condition is not going to be treated solely
14 by gender-affirming intervention. We need to
15 integrate those treatment recommendations
16 together.

17 And so that would be -- it would be more
18 of, like, a coordinating sort of -- there's
19 an interdisciplinary approach to it where I
20 address the issues that are appropriate for
21 me to address as a psychologist but the
22 medical folks are the ones who would say, you
23 know, physically or medically this person can
24 tolerate this or they understand the risks
25 and the benefits of the medical aspects of

1 it. So my part was really only one piece of
2 it. And then that was an independent
3 evaluation that would go to the Virginia DOC
4 and then their committee would take into
5 account my evaluation, the physician
6 recommendations, and then their in-house
7 folks who had usually already done their own
8 gender dysphoria-related evaluations that
9 were just diagnostic prior to my engagement.

10 Q. Okay. So just to make sure I understand
11 this, using the term psychologically
12 beneficial, in any of these evaluations were
13 you making a recommendation that
14 gender-affirming surgery would be or would
15 not be psychologically beneficial to the
16 plaint- -- excuse me, to the patient?

17 A. I don't believe I have offered either of
18 those opinions.

19 Q. Okay. When you were conducting these
20 evaluations, were you using any clinical
21 guidelines?

22 A. Well, so we have some -- as psychologists we
23 have some guidelines. There were some that
24 were published in 2008 and there were some
25 that were published in 2015 by the American

1 Psychological Association task force.
2 However, those are general guidelines for
3 psychologists, not necessarily for forensic
4 psychologists, and I think it's important to
5 acknowledge the caveat that we don't have as
6 much guidance in the forensic setting in the
7 correctional setting. It's part of the
8 reason -- it was part of the impetus behind
9 the book chapter.

10 Q. Okay. You've shared your views on WPATH.
11 Were you using or referring to the standards
12 of care when you were conducting these
13 evaluations?

14 A. Not in the correctional setting because the
15 questions that are asked by Virginia DOC,
16 they don't necessarily -- at the time at
17 least, they hadn't necessarily deferred to
18 WPATH so they had their own requirements,
19 although, like I said, my -- mine was only
20 really one piece of it. They had intern- --
21 an internal process with people and a panel,
22 I believe, that I was not involved with.

23 Q. Okay. To clarify, what do you mean deferred
24 to WPATH?

25 A. Well, you mean -- I'm sorry. You mean --

1 Q. You said at the time, the system didn't defer
2 to WPATH.

3 A. They had their own administrative
4 procedures --

5 Q. Okay. I see.

6 A. -- that didn't necessarily map onto what
7 WPATH or -- or even reference WPATH at that
8 time.

9 Q. Okay. Do you know if they do now?

10 A. I do not know.

11 Q. Is there anything else in your employment and
12 clinical history that you think is important
13 to understand as relevant to this case?

14 A. Not that I can think of.

15 Q. Okay. So in -- in light of what we've
16 discussed, when it comes to evaluating
17 patients with gender dysphoria for
18 gender-affirming surgery, do you consider
19 yourself to be an expert?

20 MR. RODRIGUEZ: Objection to form. You
21 can answer.

22 A. I have expertise in that area. If I were
23 qualified as an expert -- I would have no
24 issue with that if I were qualified by a
25 court. I don't consider myself to be

1 somebody who is promoting myself as an expert
2 very broadly in that. I'm really focused
3 specifically on the kinds of evaluations that
4 I do. In the car- -- and it -- and it's
5 broader than carceral settings, too, because
6 it's other forensic settings outside of that.
7 But I would say that, yes, I -- I am an
8 expert in conducting evaluations related to
9 gender development and psychological aspects
10 of gender-affirming care.

11 So I think it -- you know, if there was
12 an area where somebody was asked me to --
13 asked me to give an opinion related to
14 expertise in that area and I felt I did not
15 have that more narrow expertise within that
16 area, I would choose not to answer that
17 question.

18 Q. Okay. Do you consider yourself to be an
19 expert in evaluating patients to determine
20 whether gender-affirming surgery would have
21 psychological benefit?

22 MR. RODRIGUEZ: Objection to form. You
23 can answer.

24 A. Yes, I think I can give opinions about
25 whether or not somebody would achieve a

1 psychological benefit.

2 Q. Okay. And so can you tell me where -- in
3 your education, training, experience,
4 et cetera, where specifically does that
5 expertise come from?

6 A. So as a psychologist, I -- well, I should say
7 clinical psychologist, I'm trained very
8 broadly in what psychological interventions
9 are likely to provide relief to indivi- --
10 individuals with various kinds of mental
11 disorders. Now, within that field that
12 doesn't mean that every psychologist is an
13 expert in every disorder, but we do under- --
14 but we are trained in the process of
15 evaluating and treating those conditions.
16 When you're going to practice in a more
17 narrow area like the forensic area or an even
18 narrower area of forensic area with
19 transgender folks, then you have a
20 combination of treatment in -- or
21 treatment -- training in graduate school.
22 There's an experiential component of actually
23 inter- -- you know, working with trans folks
24 as opposed to simply reading about it in a
25 book and then there's also the publications

1 that I've done and the trainings that I've
2 created and co- -- cofacilitated.

3 I wouldn't say that that means that I
4 could be -- that I would be the right expert
5 for every case where that's the question.
6 There could certainly be factors in play that
7 would cause me to feel that I would not be
8 the right expert or that I lack the
9 appropriate expertise and in that case, I
10 simply would not take the referral and I
11 would do my best to make a tailored referral
12 to somebody who I felt did have that
13 expertise. So, for example, there could be a
14 cultural minority group where I just don't
15 know enough about that and even though the
16 question relates to treatment in a carceral
17 environment for a transgender person, I might
18 still say, I'm not expert in this.

19 Q. Uh-huh. Anything else in your career,
20 training, or experience that gives you
21 expertise in evaluating a patient with gender
22 dysphoria for gender-affirming surgery?

23 A. I don't recall if we've mentioned this yet,
24 but I did do some psychotherapy with folks
25 when I was still doing that with people who

1 were in the process of seeking
2 gender-affirming treatment and most of those
3 folks were still in the process of seeking
4 kind of -- you know, for most people, they do
5 endocrine treatment initially and most of
6 those folks were at that phase. They were
7 younger folks, you know, typically, like,
8 late adolescents.

9 Q. And did the psychotherapy ever involve
10 evaluation for surgery?

11 A. So I wrote letters for folks do- --
12 documenting that they had a diagnosis of
13 gender dysphoria, that their other conditions
14 were relatively well managed, that they had
15 been socially transitioned for a period of
16 time. I wrote those kinds of letters for
17 folks to utilize to seek services.

18 Q. Okay. Does services mean -- sorry. What
19 does services mean?

20 A. Yeah. So if they were going to go to get
21 even endocrine management, they would
22 typically want -- their -- their doc- --
23 their physician would often want a letter
24 from someone like myself. So those folks
25 could have approached me saying, I just want

1 the letter, can we do an evaluation, but
2 typically, what they wanted was
3 psychotherapy, supportive psychotherapy,
4 through that -- throughout that process as
5 well. So this is when I was still doing
6 therapy.

7 Q. Uh-huh.

8 A. In recent years, I only do forensic
9 evaluations so I don't do any of that
10 anymore.

11 Q. Okay. And did the services that you're
12 referring to ever include surgery?

13 A. Nobody that I was working with was at the
14 point where surgery was the next step. For
15 mo- -- for most of the ones that I recall, it
16 was part of their plan, but they weren't at
17 the point of that being the next step.

18 Q. Okay. And so just so I understand all of
19 your answers, has there ever been a time in
20 your career where you evaluated a patient
21 with gender dysphoria and you made a
22 recommendation that gender-affirming surgery
23 either would or wouldn't confer a
24 psychological benefit?

25 MR. RODRIGUEZ: Objection to form. You

1 can answer.

2 A. It's possible that I may have said that, you
3 know, for somebody having a procedure that
4 they would get a psychological benefit from
5 it. I don't remember enough detail about it
6 to provide you with more of an answer than
7 that.

8 Q. Okay. And I want to go back to something you
9 said a moment ago when you're writing
10 letters.

11 A. Uh-huh.

12 Q. You said that -- I think you said that their
13 other conditions had to be relatively well
14 managed; is that right?

15 A. Right.

16 Q. What does that mean?

17 A. Well, historically, we -- you know, there's a
18 little bit of vagueness in the language.
19 That's from the WPATH Standards of Care 7.
20 The idea was that if the person has
21 cooccurring conditions like -- let's say if
22 they have schizophrenia or something like
23 that, that they need to be generally
24 stabilized on their medication treatment
25 regimen. Their symptoms need to not be

1 fluctuating too much or so out of control
2 that they're, you know, frequently being
3 hospitalized or something like that. That
4 was the guidance from the standards of care
5 at that time.

6 Q. Pausing to take a drink of water. Excuse me.
7 Okay. Turning back to your report.

8 A. Uh-huh.

9 Q. Did you draft this report?

10 A. Yes.

11 Q. Okay. Did anyone else draft this report?

12 A. No one else has -- this is my writing.

13 Q. Okay. Oth- -- other than attorneys for the
14 defendants, did anyone else participate in
15 drafting this report?

16 A. Oh, no.

17 Q. Okay. Did you speak to anyone other than
18 defendants' attorneys about drafting this
19 report?

20 A. I believe I informed Kanautica that I would
21 be drafting a report when I met with her, but
22 she didn't see, like, a version of it
23 beforehand or anything.

24 Q. Okay. Anyone else?

25 A. No.

1 Q. Not -- Dr. Joseph Penn?

2 A. No.

3 Q. Okay.

4 A. I've actually never spoken with Dr. Penn.

5 Q. Okay. Did you review documents in preparing
6 this report?

7 A. Yes.

8 Q. What documents were those?

9 A. There were medical records which were cited
10 to in the report. The earlier -- I think the
11 earlier declaration may have provided more
12 detail about the rec- -- the records that I
13 reviewed, but there were numerous medical
14 records that were provided to me. I also
15 reviewed Ms. Zayre's -- Mrs. Zayre-Brown's
16 deposition, the video, and there was a
17 transcript that was provided to me as well.

18 Q. Okay. And I'll just point out it's -- it's
19 pronounced Zayre.

20 A. Zayre?

21 Q. I even was mispronouncing it for a while.
22 It's Zayre-Brown --

23 A. Okay.

24 Q. -- so for --

25 A. Thank you.

1 Q. Sure.

2 A. Oh, and I also read Dr. Ettner's submissions.

3 Q. Okay. Did you request any other documents
4 for the purpose of preparing this report?

5 A. I don't believe so.

6 Q. All right. Did the attorneys for the
7 defendants instruct you to make any
8 assumptions in preparing this report?

9 A. Not that I recall. I mean, I should say
10 there's a referral question, right, but
11 that -- nobody asked me to make any
12 assumptions about anything being true or not.

13 Q. All right. Was there any other information
14 provided to you for the purpose of preparing
15 this report?

16 A. So Dr. Ettner's testing was provided to me,
17 most of the raw data for Beck Depression
18 Inventory, Beck Anxiety Inventory, and the
19 Trauma Symptom Inventory. And then
20 obviously, there was the examination that I
21 did including testing.

22 Q. And you said you'd never spoken to Dr. Penn.
23 Have you spoken to Dr. Li about the report
24 that she submitted in this case?

25 A. No.

1 Q. All right. So what opinions have you reached
2 in this case?

3 A. So on Page 3 of my report there's a section
4 called, Summaries of Opinion, and that's
5 where I identify the four primary opinions
6 and conclusions. The first opinion is
7 essentially that in my view, there were
8 deficiencies in Dr. Ettner's assessment; that
9 secondly, I don't believe that a clinical
10 psychologist can reasonably predict with
11 confidence that a particular intervention
12 will be curative of gender dysphoria; and
13 that -- also, that my evaluation of
14 Ms. Zayre-Brown -- Mrs. Zayre-Brown did not
15 reveal significant find- -- findings from her
16 current mental status that would counsel in
17 favor of pushing the timing up so that it
18 would be -- the procedure would be done while
19 she's incarcerated based on her statements.
20 And then the fourth aspect of my opinion was
21 that based on the totality of information
22 that I've reviewed, Mrs. Zayre-Brown's gender
23 dysphoria is multifaceted and has multiple
24 contributions aside from the fact -- aside
25 from the contribution of not having had

1 the -- the vulvoplasty or vaginoplasty that
2 she wants. So those are the four primary
3 opinions that I offered.

4 Q. Okay. You say primary opinions. Are there
5 other opinions in here?

6 A. Well, the -- you know, for example, when I
7 say that the con- -- Dr. Ettner's process was
8 undermined by deficiencies, there's, like,
9 secondary, you know, critiques to that that
10 are --

11 Q. Uh-huh.

12 A. -- covered under that umbrella is what I
13 mean.

14 Q. Okay. All right. I'm going to flip to Page
15 33 and I'm looking at Conclusion Number
16 (1)(a). You write, A psychologist who lacks
17 formal medical education and training should
18 not offer medical opinions, e.g., medical
19 necessity, or state that their opinions are
20 reliable and valid to a reasonable degree of
21 medical certainty.

22 Did I read that right?

23 A. Yes.

24 Q. All right. What is your basis for this
25 opinion?

1 A. Ethically, we're obligated not to offer
2 opinions that are outside the bounds of our
3 competence and our training. If you're not a
4 medical provider, you shouldn't be giving a
5 medical opinion. So, for example, if I'm
6 testifying in court and someone asks me to
7 give an opinion that's fundamentally a
8 neurological opinion --

9 Q. Uh-huh.

10 A. -- or a -- a question about, well, if we gave
11 this person this medicine, do you think it
12 would make them feel better, I can't answer
13 that question because I'm not a medical
14 doctor and that's what I would say is, that's
15 a medical question. You need a medical
16 doctor to answer that. It's outside the
17 bound of my com- -- bounds of my competence
18 as a psychologist.

19 Q. Okay. And you said it -- it -- it's an
20 ethical matter. Is there a -- you know, a
21 published ethical code that you follow?

22 A. Yes. So there's APA ethics code and then
23 there's -- they call them guidelines.
24 They're all guidelines, but the -- there's a
25 forensic specialty guideline ethics code as

1 well.

2 Q. Okay. So are -- are you providing an opinion
3 in this case on medical necessity?

4 A. No.

5 Q. All right. In your view, can a psychologist
6 like yourself or Dr. Ettner ethically provide
7 an opinion on whether something is
8 psychologically necessary or perhaps, as you
9 put it, can provide a psychological benefit?

10 A. Yes.

11 Q. All right. I'd like to spend a little bit
12 more time on that term. What does -- what
13 does it mean for something to have a
14 psychological benefit or to be
15 psychologically beneficial?

16 A. Right. So --

17 MR. RODRIGUEZ: Objection.

18 A. -- typically, we're talking about treatment
19 in this context, right, some kind of
20 intervention that would be delivered to the
21 person. So beneficial generally refers to
22 either we're managing the person's symptoms
23 so that they don't get worse or we're
24 actually ameliorating the symptoms so that
25 they improve, which might not mean that

1 they're cured and it might not even mean that
2 they no longer meet diagnostic criteria for
3 it, but they might have a significant relief
4 in terms of the emotional pain that they're
5 experiencing or cognitive limitations or
6 behavioral problems that they're having. In
7 some cases it can, you know, kind of at the
8 extreme be essentially curative whereby the
9 symptoms are ameliorated to the point that
10 you fall below the diagnostic threshold. You
11 may still have some persisting symptoms that
12 are bothersome to you, but you no longer meet
13 criteria. Occasionally, there are
14 interventions that can be essentially
15 curative, but for many psychological
16 conditions, we often don't necessarily think
17 of them as being cured but, rather, in
18 remission because of the tendency that a lot
19 of psychological conditions have to come
20 back.

21 Q. Uh-huh. And so psychologically beneficial
22 would encompass all of those things that you
23 just mentioned; is that right?

24 A. Yes.

25 Q. Okay.

1 A. But it's still important to make the
2 distinction because we don't want to assume
3 that because something is psychologically
4 beneficial that that also makes it curative.

5 Q. Okay. And I think you told me what curative
6 means a moment ago, but can you tell me again
7 what -- what does it mean to be curative?

8 A. Well, curative is not a technical term.

9 Q. Uh-huh.

10 A. But essentially, what we mean is that there's
11 either a condition where the person's
12 symptoms drop below the level that's
13 required -- the threshold that's required for
14 a diagnosis, right. We use this Diagnostic
15 and Statistical Manual. It has criteria that
16 you have to satisfy in order to have a --
17 meet criteria to have a certain condition.
18 You know, let's say that you have to have
19 four of those criteria. With significant,
20 you know, benefit from psychological
21 treatment, you may drop down to only having
22 two of them. You still have those two
23 things. They might be bothersome to you, but
24 because you don't have four, you don't
25 qualify for the disorder anymore. So I would

1 not consider that curative; I would still
2 consider that to be an amelioration.
3 Curative would be you have no symptoms of the
4 condition.

5 Q. Understood. So is there a difference between
6 a treatment being psychologically beneficial
7 and medically necessary or medically
8 beneficial, whatever the correct term is?

9 MR. RODRIGUEZ: Objection, medical
10 opinion, but you can answer.

11 A. Yeah. There is a difference and that's why I
12 don't -- that's why I can give an opinion
13 about benefit without giving a medical
14 opinion. So, you know, if somebody asked me,
15 you know, if this person has electroshock
16 therapy, will their depression be cured, I
17 wouldn't be able to give an opinion about
18 that. What I could give an opinion about is,
19 here's what seems to be contributing to their
20 depression. Here's what parts of it appear
21 to be biological or sort of mechanical issues
22 with their brain.

23 Q. Uh-huh.

24 A. But here are the other things that may not
25 be. And so here's why we have reason to

1 believe that the person may need more than
2 ECT.

3 Q. Okay. When it comes to gender-affirming
4 surgery, in your view, can that ever be -- or
5 could it ever be psychologically beneficial
6 but not medically necessary?

7 MR. RODRIGUEZ: Objection, medical
8 opinion. You can answer.

9 A. So saying something's not medically necessary
10 would be giving an opinion about medical
11 necessity so I would not give that opinion.
12 What I would endeavor to do instead would --
13 to be very clear about for psychological
14 benefit, you know, what does that mean, when,
15 how, who, what.

16 Q. Uh-huh.

17 A. What are the circumstances where the person
18 is most likely to achieve the best
19 psychological benefit that they can get. I
20 wouldn't give an opinion about, you know,
21 this surgical technique versus that surgical
22 technique or this medication versus that
23 medication.

24 Q. In your experience, in your training, are you
25 aware of any patient who was seeking

1 gender-affirming surgery and their providers
2 determined that, yes, it's psychologically --
3 it would be psychologically beneficial, but,
4 no, it wouldn't be medically necessary?

5 A. I'm not typically privy to how the internal
6 committees within the Virginia -- for
7 example, Virginia DOC make those kind of
8 determinations so I don't usually even know
9 what necessarily happens in terms of the
10 endpoint of those cases. So I'm not sure
11 what kind of determination was made by those
12 kinds of panels.

13 Q. Okay. So in your view, who would be
14 qualified to make a determination on medical
15 necessity for gender-affirming surgery?

16 MR. RODRIGUEZ: Objection, medical
17 opinion, outside the scope of this expert's
18 opinions. You can answer.

19 A. So if some were to -- someone were to ask me
20 for a referral for that, I would say it would
21 need to be a medical professional, but the
22 type of medical professional could depend
23 largely on the individual person, what their
24 needs were and what they were asking for. So
25 a lot of times, an interdisciplinary approach

1 is a pretty helpful one for that where you've
2 got a couple of different kinds of medical
3 doctors so you might have an endocrinologist
4 as well as a surgeon and a psychiatrist, for
5 example.

6 Q. And do you have a sense of how a medical
7 provider would go about determining whether
8 surgery's medically necessary?

9 MR. RODRIGUEZ: Objection, medical
10 opinion, speculation. You can answer.

11 A. I don't feel enough -- I don't feel that I
12 know enough to say whether or not I know
13 enough about that. I'm not -- I'm not
14 familiar enough with the decision-making
15 processes that they utilize for medical
16 necessity to be able to give an opinion about
17 that.

18 Q. Okay. Are you familiar at all?

19 A. I've certainly read depositions where
20 physicians were discussing medical necessity.
21 The -- I don't think that I'm an expert on
22 medical necessity. I wouldn't give an
23 opinion about medical necessity.

24 Q. Okay. Let's flip to Page 5 of your report.

25 A. Uh-huh.

1 Q. So I am in the second paragraph, last
2 sentence, and you write, I know other
3 psychologists like Dr. Ettner and I who also
4 perform similar evaluations related to
5 gender-affirming care for transgender and
6 gender-nonconforming individuals and, in my
7 experience, it would not be typical for them
8 to offer medical opinions.

9 Did I get that all right?

10 A. Yes.

11 Q. All right. Who were the other psychologists
12 you're referring to?

13 A. So one would be Dr. Olezeski and her
14 colleagues at the Yale clinic. These are
15 the -- some of the folks that I was thinking
16 of in particular because they conduct a lot
17 of trainings. The last one they did was for
18 the APA last year and although they don't
19 offer medical opinions, they work
20 collaboratively with medical doctors so
21 they're not completely siloed off.

22 Q. Uh-huh. Anyone other than Dr. Olezeski, if
23 I'm pronouncing that correctly?

24 A. Yes, you are pronouncing that correctly. So
25 Sarah Miller, my coauthor. I don't believe

1 Dr. Campbell has offered those opinions,
2 who's also my coauthor on that chapter.

3 Q. What is Dr. Campbell's first name?

4 A. Walter.

5 Q. Okay. So you say it's not typical for them
6 to offer medical opinions. Do they ever
7 offer medical opinions?

8 A. I can't say that I know enough about all of
9 those individuals and everything they've ever
10 said or did to be able to say they have never
11 offered an opinion that I would not consider
12 to be a medical opinion. So I can't -- I
13 don't think I have the foundation and
14 knowledge to answer that, but my
15 understanding in my interaction with those
16 folks is that they would -- their ethical
17 principle would be not to offer one because
18 it's outside the scope of their competence --

19 Q. Uh-huh.

20 A. -- and I've never known them to do that.

21 Q. Okay. So for this assertion in your
22 report -- excuse me, your report concerning
23 offering medical opinions when you're a
24 psychologist, are you relying on anything
25 beyond your personal professional experience?

1 A. Well, so we have authoritative texts that
2 provide guidance on these topics. We --
3 there's a -- Mental Health Evaluations for
4 the Courts by Melton and colleagues is sort
5 of one of our foremost texts that we would
6 cite to that talks specifically about the
7 importance of maintaining -- staying within
8 the bounds of your competency as a
9 psychologist. This is reiterated in our
10 ethics code broadly, in our forensic
11 guidelines more narrowly. Additionally,
12 you'll see this in virtually any discussion
13 of forensic psychological practice because
14 it's not just that we shouldn't give medical
15 opinions -- that's one pitfall, one kind of
16 potential land mine for us.

17 Q. Uh-huh.

18 A. -- but also that we ought not offer legal
19 opinions. That's the other area where we're
20 significantly cautioned is not to offer legal
21 opinions unless we are -- you know, like I
22 said, I have colleagues who are J.D./Ph.D.s.
23 that they might, but if you're just a
24 psychologist, you would not. So it's not
25 specific just to medicine.

1 Q. Okay. And these authoritative texts, do they
2 say specifically something along the lines
3 of, you know, forensic psychologists cannot,
4 should not make recommendations concerning
5 medical necessity?

6 A. I don't have a specific recollection that
7 that -- the exact language regarding medical
8 necessity. I would have to look at the text
9 and see if that's an accurate representation
10 of what they say.

11 Q. Yeah. Well, I mean, I don't expect you to
12 remember offhand exactly what it says.

13 A. Uh-huh.

14 Q. Do you recall that it says something like
15 that?

16 A. No.

17 Q. Okay.

18 A. I don't have a recollection.

19 Q. Okay. So can a psychologist, in your view,
20 refer a patient -- can a psychologist refer a
21 patient seeking gender-affirming surgery to a
22 medical provider?

23 A. Yes.

24 Q. Okay. That's permitted by WPATH standards?

25 A. Well, in fact, WPATH talks about an

1 interdisciplinary approach at times. But an
2 interdisciplinary approach could come because
3 somebody goes to a clinic and the clinic
4 takes an interdisciplinary approach or they
5 could come to an individual psychologist or
6 other mental health care provider or even
7 their doctor and that person could refer them
8 for intervention.

9 Q. Okay. So in terms of just what a -- a
10 patient's care looks like --

11 A. Uh-huh.

12 Q. -- in your view, it's appropriate for a
13 psychologist to conduct an evaluation, say, I
14 think this treatment, surgery, or whatever
15 would have psychological benefit, and I'm
16 going to refer you along to a surgeon,
17 endocrinologist, whoever?

18 A. Right. You -- I mean, you would also
19 typically discuss whether or not a diagnosis
20 of gender dysphoria is present or absent.

21 Q. Okay. All right. So still on Page 5. Bear
22 with me just one moment. All right. I'm
23 sorry. So this is second paragraph and it's
24 four lines down. Thus, my role in such cases
25 is not to make determinations regarding

1 whether a person should or should not receive
2 a given intervention.

3 Did I read that correctly?

4 A. Yes.

5 Q. All right. And then let's flip to Page 2.
6 And you say that part of your role is to
7 offer recommendations with respect to
8 gender-affirming interventions; is that
9 right?

10 A. Right.

11 MR. RODRIGUEZ: Can you --

12 MR. SIEGEL: I'm sorry.

13 MR. RODRIGUEZ: Where are you -- yeah,
14 where are you reading?

15 MR. SIEGEL: I'm sorry. Where is it?
16 I don't have it highlighted on my copy.

17 BY MR. SIEGEL:

18 Q. Sorry. Bear with me just one moment, y'all.

19 MS. MAFFETORE: It's the first line --

20 MR. SIEGEL: Okay.

21 MS. MAFFETORE: -- on the second page,
22 to offer recommendations with respect to --

23 MR. SIEGEL: Okay. Thank you.

24 MS. MAFFETORE: -- gender-affirming --

25 BY MR. SIEGEL:

1 Q. All right. So it's -- yeah. It's the very
2 first line after the comma, Part of your role
3 is to offer recommendations with respect to
4 gender-affirming interventions or building
5 capacity to provide informed consent.

6 A. Uh-huh.

7 Q. All right. So did those statements that I
8 just read, the one on Page 2 and the one on
9 Page 5 -- is there any contradiction between
10 those statements?

11 A. I think part of the difficulty that we're
12 having here is that we're maybe confusing
13 making recommendations with respect to
14 gender-affirming interventions with
15 recommending specific gender-affirming
16 interventions.

17 Q. Okay.

18 A. So what I don't do is I don't say, this
19 person needs to have this surgery or this
20 person should not have this surgery. I
21 don't --

22 Q. Uh-huh.

23 A. -- say either one of those things.

24 Q. Okay.

25 A. But what I might say is, you know, what this

1 person has articulated is that they would
2 like to -- you know, for example, I might
3 say, I think they should be provided with
4 information about what their options would be
5 for bottom half surgery because what they've
6 described in terms of their ultimate goal
7 might necessitate that based on how they've
8 described the presentation that they want.
9 So I might recommend, for example, like, they
10 should be provided with more information
11 about that and here's how they should be
12 provided with that information. I might say,
13 they would learn best -- if they're a bright
14 person who likes to read, maybe give them a
15 book. If they're not or they have literacy
16 problems, I might make recommendations that
17 are different. So it's not that I'm
18 recommending what interventions they should
19 have, but I'm providing recommendations
20 related to gender-affirming interventions
21 without saying that they should or should not
22 have them.

23 Q. And so in this case, you -- are you providing
24 an opinion whether Mrs. Zayre-Brown should or
25 should not receive a certain treatment?

1 A. I haven't given an opinion about whether or
2 not she should -- from my perspective she
3 should or should not receive a given
4 treatment, but what I have done and can do is
5 describe what she has said she wants.

6 Q. Okay.

7 MR. SIEGEL: Let's take a short break,
8 if that's all right with y'all.

9 MR. RODRIGUEZ: Yeah.

10 (Whereupon, there was a recess in the
11 proceedings from 11:00 a.m. to 11:09 a.m.)

12 BY MR. SIEGEL:

13 Q. Welcome back, Dr. Boyd.

14 A. Uh-huh.

15 Q. All right. Changing gears somewhat. Are you
16 familiar with the Division Transgender
17 Accommodations Review Committee or DTARC?

18 A. I am familiar with their existence. I'm
19 familiar with them to the extent that their
20 activities were documented in the records
21 that I reviewed, but I don't have independent
22 knowledge of them outside of the information
23 I reviewed in this case.

24 Q. Okay. So based on what you reviewed, excuse
25 me, what is the DTARC?

1 A. It's a committee that I believe reviews
2 requests and then provides approvals for
3 various stages of the process. So there are
4 administrative processes for approving
5 evaluations, scheduling consultations, and
6 then approving procedures.

7 Q. Do you know who's on it?

8 A. No.

9 Q. Are you familiar with their decision last
10 year to deny Mrs. Zayre-Brown's request for
11 gender-affirming surgery?

12 A. Yes.

13 Q. Do you have an understanding of how DTARC
14 reached that decision?

15 A. No. My primary focus was about how
16 Mrs. Zayre- -- Zayre-Brown received the news
17 and responded to it --

18 Q. Okay.

19 A. -- more than the deliberation.

20 Q. Okay. I'm going to hand you another exhibit.
21 I think this is Exhibit Number 3 that we're
22 on.

23 (BOYD EXHIBIT 3, Division Transgender
24 Accommodation Review Committee (TARC) Report,
25 2/17/2022, was marked for identification.)

1 BY MR. SIEGEL:

2 Q. Dr. Boyd, have you seen this document before?

3 A. This actually may have been included in the
4 records that I reviewed. This front page
5 does not look fam- -- as familiar, but the --
6 the second and third page does.

7 Q. Okay.

8 A. Although it's possible that it looks familiar
9 because it was cut and pasted from another
10 section of the records. That often happens.

11 Q. Okay. So take another moment to review if
12 you'd like --

13 A. Sure.

14 Q. -- and then just let me know what this
15 document is --

16 A. I will tell --

17 Q. -- or appears to be.

18 A. Yes. So this appears to be a report that
19 documents a determination that was made by
20 the -- the Division Transgender Accommodation
21 Review Committee. So it documents what
22 information they reviewed. It provides a
23 brief narrative and a medical analysis is the
24 latter portion. It details who was in
25 attendance at the time of the meeting and on

1 the front -- on the cover sheet there's an
2 indication that the purpose of the review was
3 related to gender-affirmation
4 surgery/vulvoplasty and the accommodations
5 referred for final determination includes the
6 decision that says, DTARC does not recommend
7 gender-affirmation surgery stating, This
8 surgery is not medically necessary.

9 Q. Okay. I think that sums it up. Are you
10 familiar at all with the professional
11 background of the -- the individual
12 defendants in this case?

13 A. No. Be- -- not beyond what their title is as
14 reflected in records.

15 Q. Okay. Do you -- do you know if any of them
16 have medical training?

17 A. I believe some do. I believe your -- that,
18 for example, your chief medical officer is a
19 physician.

20 Q. All right. Any of the others to your
21 knowledge?

22 A. My -- well, typically, the chief of
23 psychiatry would be a psychiatrist, who's
24 also a medical doctor, so it's likely that
25 person is also a physician.

1 Q. Okay. So based on this document, the DTARC
2 recommended that gender-affirming surgery was
3 not medically necessary, correct?

4 A. That's what the form states, yes.

5 Q. Okay. So if any of the members of the DTARC
6 who participated in this recommendation did
7 not have medical training, would that have
8 been appropriate in your view?

9 MR. RODRIGUEZ: Objection to form. You
10 can answer.

11 A. So that's a -- this is a good example of why
12 the interdisciplinary approach is important.
13 So you can see there's a medical analysis
14 section that -- there's a heading specific to
15 that. I would suggest that someone without a
16 medical degree should not be involved in the
17 decision-making regarding, like, the
18 deter- -- the actual determination as far as
19 saying this is medically necessary or not.
20 However, it may benefit the folks who have
21 the background to men- -- make the medical
22 determination to have the input from folks
23 who have a background in mental health and/or
24 who are administrative folks who know more
25 about what the internal regulations and

1 requirements are so they can have input and
2 they may provide information that the folks
3 who make the medical determination find
4 relevant and necessary. But as far as who
5 signs off on the medical analysis and who
6 drafts it, in my opinion, that should be a
7 physician -- it should be someone with a
8 medical degree.

9 Q. Understood. Okay. You can set this aside if
10 you'd like. So a lot of your report is
11 talking about informed consent and you've
12 spoken about that some today. I'll just ask
13 a very basic question of what is informed
14 consent and why does it matter?

15 A. Right. So informed consent, broadly
16 speaking, refers to the necessity for
17 individuals who are participating in
18 treatment or evaluation to knowledgeably
19 agree to participate or receive that
20 treatment or evaluation. So that's, like, in
21 the very broadest sense. And informed
22 consents in our practice as psychologists
23 means that people are knowingly participating
24 in -- whether it's an evaluation or
25 treatment, that they are a -- given the

1 opportunity to be provided with the
2 information that they need to understand the
3 risks and the benefits, the costs, and, you
4 know, have a reasonable and reality-based
5 appraisal of that before they are asked to
6 make a decision. There's two parts to it.
7 One is making sure they have the information.
8 The other part is the autonomy of the
9 individual to choose to participate or not.

10 Informed consent in terms of providing
11 care to folks who are transgender has -- is
12 slightly different. So we still have the
13 core informed consent obligations that we're
14 required to maintain ethically in terms of
15 our practice, doing evaluations or -- or
16 doing treatment, but informed consent is
17 also, somewhat confusingly, the name of a
18 different kind of approach to assessing
19 individuals and providing treatment to
20 individuals who are transgender, whether
21 they're in the community or a carceral
22 setting. It's not specific to a setting.
23 And what it means is that instead of saying
24 that our role is to decide if somebody is
25 trans or not, instead, our role is to make

1 sure that the person not only has the
2 capacity, right -- which capacity doesn't
3 mean you already have all the information; it
4 just means you have the ability to understand
5 and process that information, make decisions.
6 Not only do they have the capacity, but have
7 they been provided with the information that
8 they need? Are they in a position to make a
9 decision about it and do they have the
10 support that they need to do that? So an
11 informed consent approach to conducting these
12 evaluations is different even though it uses
13 the same terminology as informed consent in
14 terms of an ethical obligation on the part of
15 psychologists when they're conducting
16 activities involving patients, clients, or
17 research participants.

18 Q. Okay. So when you are evaluating patients
19 for informed consent meaning, I think --
20 well, let -- I'll let you answer that. When
21 you're evaluating a patient for informed
22 consent, which one of those do you mean --

23 A. Right.

24 Q. -- and how do you do it?

25 A. Right. Well, unfortunately, another

1 complicated answer.

2 Q. Okay. Great.

3 A. So one version of looking at this could be,
4 like, a Miran- -- a competency to waive
5 Miranda evaluation, which is retrospective
6 and it's looking at whether or not the person
7 knowingly, intelligently, and voluntarily
8 waived their rights to a custodial
9 interrogation so you might look at their
10 capacity. Do they have an intellectual
11 disability, do they have a severe psychiatric
12 problem, were they under severe stress,
13 things like that. So that's one area where
14 it's -- you know, that's one area where it's
15 different.

16 But informed consent in this process
17 refers more to positioning the individual
18 who's seeking treatment in such a way that
19 they can access the support that they need,
20 have the information that they need delivered
21 in -- to them in a way that they understand
22 so that they can make a decision
23 collaboratively with their treating
24 professionals about what treatment they need,
25 when they should get it, how it should be

1 delivered.

2 Q. In this case did you assess
3 Mrs. Zayre-Brown's ability to provide
4 informed consent?

5 A. I used an informed consent approach and part
6 of that was assessing her capacity to provide
7 informed consent and I did ultimately come to
8 an opinion regarding that.

9 Q. Okay. How did you go about making that
10 assessment?

11 A. I looked for the presence of any conditions
12 that could potentially interfere with her
13 capacity to provide informed consent and then
14 I just asked her direct questions to
15 ascertain her fund of knowledge and her
16 beliefs about different kinds of scenarios
17 and options.

18 Q. Okay. Could you be a bit more specific on --

19 A. Certainly.

20 Q. -- how you did that.

21 A. Yes. So in reviewing her records, for
22 example, I looked for conditions that could
23 be expected to potentially, even just in a
24 time-limited way, impair her capacity to
25 provide informed consent. So I looked at

1 mood issues, cognitive issues. Those are
2 the -- those issues and psychosis are the
3 most common kind of barriers to that.

4 After you see whether or not those
5 things are present, if they are present, then
6 you look to see, are they relevant? In other
7 words, are they active now when the person --
8 or during the relevant time period when
9 you're looking at the decision-making, which
10 for Mrs. Zay- -- Zayre-Brown is now.

11 So she does have some cooccurring
12 conditions. You know, in my view, though, at
13 the time that I saw her, those symptoms were
14 not so active or impairing that they would
15 impair her capacity to understand what her
16 options are and make decisions.

17 Q. Okay. Does that mean you concluded that she
18 can provide informed consent?

19 A. I believe she has the capacity to provide
20 informed consent in that, you know, narrow --
21 more narrow kind of ethical obligation of
22 ensuring that she's not, for example,
23 agreeing to a procedure when -- in a --
24 without a reality-based understanding.

25 Q. Okay. If you could flip to Page 31 of your

1 report. And this is beginning of Section E.
2 Sorry. I'll wait till -- for you get there.

3 A. Yes.

4 Q. Oh, I'm sorry. It's actually the -- the
5 first full paragraph on the page, which
6 reads, Mrs. Zayre-Brown's expectancies for
7 the surgical aftercare that would be
8 available to her in prison were less
9 realistic in light of history.

10 What does that mean?

11 A. So this interview was -- was video recorded.

12 Q. Uh-huh.

13 A. And this is a reference in part to the
14 discussion that Mrs. Zayre-Brown and I had
15 about her experience when she initially
16 entered custody and had had surgery about a
17 month before that -- be- -- before her
18 sentencing. And so she was still recovering
19 from a surgical procedure and that's where
20 the -- part of where that relevant
21 conversation started. We discussed what care
22 she had already received and that's why I say
23 in light of the history. When I say that her
24 expectancies for surgical aftercare that
25 would be available to her in prison were less

1 realistic, I say that because what she was
2 describing in terms of what she expected to
3 receive in terms of aftercare was a radical
4 departure from what -- the care she described
5 actually receiving.

6 Q. Okay. And the care that she described
7 receiving with respect to recovering from the
8 orchiectomy --

9 A. Yes.

10 Q. -- in 2017; is that correct?

11 A. Yes.

12 Q. All right. Was there a -- anything else in
13 your assessment that contributed to your
14 statement here that her views were less
15 realistic about aftercare?

16 A. So here we're talking about surgical
17 aftercare specifically --

18 Q. Uh-huh.

19 A. -- so not other elements of aftercare. And,
20 yeah, so that particular statement is related
21 to that discussion.

22 Q. Okay. And so my question is, was there any
23 other statement that she made or any other
24 part of your assessment that contributed to
25 that observation you made?

1 A. The result of her formal testing by me --

2 Q. Uh-huh.

3 A. -- indicate that she has a personality style
4 where she is -- she has a tendency to, like,
5 idealize situations sometimes that are
6 prospectively positive so that can cause her
7 to be a little bit like a cork on the ocean
8 where a good thing happens or something seems
9 like it's going to be really promising and
10 relieving and her mood goes up significantly.
11 At the same time, when she gets news that
12 something is not going to happen, her mood
13 can drop down really dramatically. And in my
14 view, that affects her ability -- when she's
15 in those states, that does affect her ability
16 to accurately appraise and anticipate what's
17 going to happen in the future, but that could
18 happen in either direction depending on the
19 circumstance. I think this is an example of
20 her idealizing what would be available to
21 her. And I say idealizing it because she is
22 com- -- I'm comparing it to what she has told
23 me about her own experiences prior to that.

24 Q. Uh-huh.

25 A. And she was not able to provide me with

1 information that was -- would indicate that
2 there were -- there was an evidence base for
3 believing that the circumstances that she
4 described as ideal for her and most likely to
5 give her relief and benefit would actually
6 happen in a prison setting.

7 Q. And what would be ideal?

8 A. So she articulated it herself and I describe
9 it on that same page, the last paragraph
10 before Section E. Her idea -- her view of an
11 ideal surgery context would include, A,
12 receiving medical care in the community,
13 including aftercare and wound care
14 management; B, the opportunity to receive
15 care and support from her husband, friends,
16 and family; and, C, participating in
17 meaningful personal and professional
18 development opportunities while she is
19 preparing for surgery and recovering from
20 surgery.

21 So this is her statement about what she
22 sees as an ideal surgery context. Now, when
23 I say she idealized things, I'm -- here
24 that's not what I'm talking about. This is
25 her -- just her self-report, her description

1 of what she thinks would be optimal for
2 her --

3 Q. Okay.

4 A. -- clinically. What she described as far as
5 what -- how she thought recovery -- what
6 recovery from this procedure could look like
7 in a prison setting, she described having
8 more access to physicians, more regular care
9 than she described having at the time that
10 she initially entered prison in 2017.

11 Q. Got it. Do you have an understanding of what
12 postsurgical care is like for a vulvoplasty?

13 A. I have some familiarity, but I can't give a
14 medical opinion.

15 Q. Okay. I'm not asking for a medical
16 opinion, just to your knowledge. Is -- is it
17 anything more complicated than basic wound
18 care?

19 A. It depends on the individual. The
20 vulvoplasty differs from vaginoplasty in that
21 most individuals, you know, there wouldn't be
22 a reason to use dilators, for example, but
23 depending on how the procedure is done, how
24 skillfully it's done, what the individual's
25 history is -- she did have complications

1 through her wound care before from the
2 orchiectomy but -- you know, it can be
3 complicated for individuals, but it -- you
4 know, it depends on the person. All I can
5 rely on for her -- from her is what she tells
6 me about what her prior experiences were with
7 her ability to manage wound care. And I
8 think it is fair to say that it's certainly a
9 risk, probably a more significant risk for
10 vaginoplasty compared to vulvoplasty, but
11 both of them would carry risks and a
12 physician would have to be the person -- a
13 surgeon would have to be the person to give
14 you an opinion.

15 Q. Okay. So other -- other than her experience
16 in 2017, do you have any other reason to be
17 concerned about the quality of aftercare
18 provided in the state prison system?

19 A. I'm re- -- again, I'm relying on her report.

20 Q. Okay.

21 A. I'm relying on what she has personally
22 experienced and the aftercare that's
23 available in one facility or for one
24 individual could be different even within the
25 same prison system.

1 Q. Speaking very generally, do you have concerns
2 about the quality of care offered in the
3 prison setting versus the community setting?

4 A. With respect to mental health care, which is
5 really what I'm able to comment on, yes.

6 Q. Okay. Could you tell me why.

7 A. Prisons are inherently stressful
8 environments. Restrictive housing in
9 particular is a highly stressful environment.
10 It's well documented that it's incredibly
11 psychologically stressful.

12 Q. Uh-huh.

13 A. The analogy I sometimes give is that
14 depending on where you're at in the prison is
15 the psychological equivalent of getting hit
16 in the head -- or getting -- yeah, getting
17 hit in the head with a hammer every day and
18 wondering why your skull isn't recovering.
19 You know, you could get medical treatment --

20 Q. Uh-huh.

21 A. -- you could get stitches, but if you're
22 still getting hit in the head with a hammer
23 every day, you're not going to get a lot
24 better. And that's part- -- partly an issue
25 of confinement. It's partly an issue of who

1 you're around, what your population is and --
2 and who your social community and your peer
3 group is and whether they're dangerous to you
4 or not. But from a mental health perspective
5 it is -- you know, we would most -- I don't
6 know any psychologist who would say that it's
7 not a -- a psychologically stressful
8 environment.

9 Q. Uh-huh.

10 A. So there's that aspect to it. Doesn't mean
11 the community can't also be stressful. Being
12 unhoused --

13 Q. Uh-huh.

14 A. -- for example -- you know, there are all
15 kinds of ways that the community can also be
16 stressful, but just as a baseline, it's a
17 more stressful environment. Sometimes people
18 have access to services in there that they
19 don't have access to in the community, but
20 overall just as a baseline, it's a different
21 environment from a psychological perspective.

22 Q. Okay. So I'm going to give you a
23 hypothetical. In your view, assuming that a
24 treatment would be psychologically beneficial
25 for a patient and is medically ne- -- excuse

1 me, medically necessary, would the quality of
2 aftercare available be a valid reason to deny
3 that treatment?

4 MR. RODRIGUEZ: Objection to form,
5 medical opinion. You can answer.

6 A. Denying the treatment would be an
7 administrative decision. It's not -- and
8 that's not a process that I'm part of. I
9 also think that the individual's perspective
10 on whether they feel they could tolerate, you
11 know, those circumstances would be something
12 to take into account. It's difficult to
13 answer that hypothetical just because it is
14 somewhat broad.

15 Q. Okay. Well, I'll narrow it a little bit. So
16 you can also assume that this person has
17 requested the surgery and has been seeking it
18 for years. And I'm not talking about really
19 the administrative decision. I'm talking
20 about a decision by the healthcare providers
21 treating the patient. So assuming all of
22 that -- so we've got patient who wants a
23 treatment. Assume that it's psychologically
24 beneficial. Assume that it's medically
25 necessary. Patient has been advocating for

1 herself for years.

2 In that case, would the quality of
3 aftercare available be a valid reason to deny
4 the treatment?

5 MR. RODRIGUEZ: Objection, medical
6 opinion, legal opinion, speculation, form.
7 You can answer.

8 A. I wouldn't say -- I wouldn't say that
9 exactly, but I would direct you to, actually,
10 Ettner's second declaration, Paragraph 38
11 where she describes a Cornell study regarding
12 outcomes for transgender folks after they've
13 had procedures done and one of the things
14 that predicts outcomes is the quality of the
15 surgical procedure and, I believe also, the
16 aftercare that's available to that
17 individual. That does affect the outcomes
18 that people have.

19 Now, you know, there's critique --
20 there's different ways to talk about that and
21 think about that. Regret rates are also
22 related to the fundamental effectiveness of
23 the surgical procedure and whether or not the
24 person ends up with the outcome that they
25 want. Now, as I'm sure you know, regret

1 rates are very, very low, but even within
2 that group, one of the things that does
3 predict it is if you don't get the surgical
4 outcome that you want physically.

5 Q. All right. So getting back to Kanautica and
6 informed consent --

7 A. Uh-huh.

8 Q. -- were there any aspects of informed consent
9 that you assessed and haven't mentioned yet
10 today?

11 A. Yes. I discuss in my report -- and forgive
12 me one second. I want to locate it, the
13 section. Okay. On Page 10 in the section
14 that has a header that starts with,
15 Dr. Ettner discounts the importance of a
16 psychologist's role in informed consent, the
17 second full paragraph, A prospective
18 patient's understanding of the likely
19 outcomes of a procedure and the timing of
20 these outcomes is key to their ability to
21 make decisions while also weighing the risks
22 and costs. Skipping down a little bit to the
23 second-to-last sentence, for example, a
24 patient who believes an intervention will be
25 curative may accept more serious or higher

1 probability risks compared to a patient who
2 believes that an intervention will alleviate
3 but not cure their symptoms. Communicating
4 to a prospective patient, continuing on to
5 the next page, Page 11, that a surgical
6 procedure will be curative carries
7 significant risk of misleading the individual
8 and influencing their decision-making with
9 inaccurate information leading to exaggerated
10 proc- -- expectancies.

11 And so here what I'm speaking about, and
12 I continue to talk about in the report, is
13 the narrative -- is the information
14 essentially that Dr. Ettner provided to
15 Mrs. Zayre-Brown saying, this will cure your
16 gender dysphoria. That is something that I
17 did get into and I discussed with
18 Mrs. Zayre-Brown because of my concern that
19 if doctors are -- authority figures are
20 coming in and telling her, this will cure
21 your gender dysphoria, and that's not true or
22 at least we can't say it with that degree of
23 confidence that that's definitely what's
24 going to happen, then that person may decide
25 to undertake procedures under riskier

1 circumstances, less optimal circumstances
2 that are likely to produce less benefit
3 because they think, this is what's going to
4 fix the pain that I'm experiencing. And so I
5 do certainly have that concern and I discuss
6 it in my report with respect to informed
7 consent, wanting to ensure that
8 Mrs. Zayre-Brown has accurate, reality-based
9 information so that -- so that she can make
10 her own decision.

11 Q. Are you expressing an opinion in this case as
12 to whether Mrs. Zayre-Brown has actually
13 provided informed consent for
14 gender-affirming surgery?

15 A. I gave the opinion that I don't believe her
16 capacity to provide informed consent was
17 significantly compromised at the time of my
18 evaluation of her so her capacity to provide
19 informed consent to most surgical procedures
20 at this point, I think, is probably intact.

21 I mentioned the information that I think
22 has been provided to her that is misleading
23 and I -- you know, obviously, I want to make
24 sure she knows that that is my perspective so
25 she has that information, too, in making her

1 decision, but the critique of Dr. Ettner is
2 more related to, like, her approach, not
3 giving Mrs. Zayre-Brown accurate information,
4 not exploring no- -- as thoroughly I think as
5 should have been done what her reasoning was
6 and what her options were, really, all of her
7 options, what is going to be best for her.
8 And so that was my critique of -- of Ettner
9 and the concern that I had with respect to
10 informed consent.

11 Q. Okay. And so I'm -- I'm just trying to
12 bet- -- to understand exactly what you're
13 saying and what you're not saying.

14 A. Uh-huh.

15 Q. So Kanautica saw Dr. Figler at UNC, right?

16 A. Yes.

17 Q. And saw some other healthcare providers,
18 right?

19 A. Yes.

20 Q. So are you expressing an opinion in this case
21 as to whether she actually provided informed
22 consent to any of those providers?

23 A. Oh, that's -- okay. So that's a good
24 question. I think it's -- when I saw her, I
25 did not see barriers to her having the

1 capacity to perform -- to provide informed
2 consent to that kind of circumstance. The
3 information that was provided in the records
4 regarding what Dr. Figler actually told
5 Ms. Zayre-Brown is very limited so it's hard
6 to ascertain whether or not she was actually
7 provided with enough information.

8 At the same time, there is a distinction
9 between the informed consent process for
10 surgery, which I believe she does have the
11 capacity -- like, I think she does understand
12 the risks and the benefits just purely from
13 the medical perspective.

14 Q. Uh-huh.

15 A. The informed consent issue for me primarily
16 relates to her psychologi- -- her
17 expectancies regarding the psychological
18 benefit that she will receive provided those
19 surgical procedure -- procedures are
20 effective.

21 Q. Okay. All right. Well, let's get back to
22 Dr. Ettner so let's flip to Page 3 of your
23 report. So this is summary of opinions.
24 Second sentence, First, the opinions and
25 conclusions of Dr. Ettner are undermined by

1 multiple deficiencies in Dr. Ettner's
2 assessment, including the failure to apply an
3 informed consent approach.

4 A. Uh-huh.

5 Q. So some of this will be slightly repetitive,
6 but what -- what do you mean here by informed
7 consent approach?

8 A. Right. So -- and this is a useful point of
9 clarification. I'm not making the assertion
10 that Dr. Ettner did not seek informed consent
11 from Mrs. Zayre-Brown to participate in the
12 psychological evaluation, but I do not know
13 if she did or she did not because it's not
14 documented. The failure to apply an informed
15 consent approach here refers to the approach
16 that Dr. Ettner took to the evaluation by not
17 giving -- in my view not giving
18 Mrs. Zayre-Brown accurate information
19 regarding what her expectancies would be --
20 you know, should be for these procedures.
21 There's very little discussion of that.
22 That's what I'm referring to in that
23 particular clause.

24 Q. Okay. So when you're talking about the
25 informed consent approach, you make a

1 comparison -- I'm sorry. I don't have the
2 exact page number -- but between what the
3 WPATH says about informed consent and a
4 different approach; is that right?

5 A. So I -- I know this is tedious because it --
6 it is nuanced, but --

7 Q. Uh-huh.

8 A. -- there's informed consent for the surgery.
9 Do I know what they're going to do? Do I
10 know what my alternatives are? Do I know the
11 risks, the cost, the prospective benefits,
12 and the relative likelihoods of those things,
13 right? So that's one issue.

14 Another issue is informed consent as an
15 approach to conducting these kinds of
16 evaluations related to somebody's access to
17 gender-affirming care, their capacity to
18 provide informed consent. That's actually
19 described in the new version of the
20 standards --

21 Q. Uh-huh.

22 A. -- the eighth version. They describe an
23 informed consent approach and that's what I'm
24 talking about is the informed consent
25 approach that's actually described in the new

1 version of the standards. That's not what
2 I'm seeing in terms of Dr. Ettner's approach.

3 Q. Uh-huh. All right. So does that, what's in
4 the new standards, require the involvement of
5 a mental health professional in order for a
6 patient to get gender-affirming care?

7 A. You mean in the informed consent model?

8 Q. Yes.

9 A. I actually -- I think it would probably not
10 be responsible for me to answer that question
11 without rereviewing that section. It's not a
12 terribly lengthy section of the standards,
13 but I -- I wouldn't want to inadvertently
14 misspeak.

15 Q. Okay. Do you know if there are any hospitals
16 or clinics that provide gender-affirming care
17 that follow this -- the informed consent
18 model?

19 A. Yes. So, for example, that -- the Yale
20 clinic --

21 Q. Uh-huh.

22 A. -- my coauthor and I -- Dr. Olezeski, we
23 discussed that in detail. The other
24 coauthors, I believe, utilize elements of
25 that in their approach, but because

1 they're -- I'm not referring to Ms. Farmer;
2 I'm referring to Drs. Miller and Campbell.
3 They are functioning within systems where
4 they're constrained because the -- it's their
5 employer --

6 Q. Uh-huh.

7 A. -- whereas, I'm typically acting as basically
8 a contractor so I can do the evaluation in
9 the way that I feel is most appropriate. I'm
10 not -- they can utilize it however they want
11 to use -- utilize it within their policies
12 and procedures, but I'm not constrained in
13 the same way that somebody who's actually
14 employed in the prison by the prison is in
15 terms of their practices.

16 So I use an informed consent approach.
17 The community-based clinics, some of them
18 including the Yale clinic do. With my other
19 colleagues on the book chapter in particular,
20 I believe they utilize it, but they have to
21 defer to other kinds of requirements in terms
22 of giving opinions that would be outside of,
23 you know, what I might sometimes see as
24 appropriate.

25 Q. Okay. So do you believe that

1 gender-affirming care should be provided to
2 patients without the involvement of a mental
3 health professional?

4 A. I think there are certainly people who could
5 absolutely have gender-affirming care without
6 the involvement of a mental health
7 professional. If they want to have boxers, I
8 don't understand why you need to talk to a
9 psychologist about that, frankly. You know,
10 that doesn't make any sense to me, but
11 they -- they do. These are procedural kind
12 of --

13 Q. Uh-huh.

14 A. These are regulatory and internal
15 administrative processes. So as a matter of
16 actual practice, yes, it is often the case
17 that we have to be involved. As a matter of
18 clinical utility, do we need to be involved
19 all the time? No, probably not.

20 Q. And -- and so what about for surgery?

21 A. I think it would depend on the individual,
22 but for most people, yes, you would have a
23 psychologist involved at least in terms of an
24 initial consultation and I would always
25 suggest that a psychologist be made available

1 to the person to ask questions and also to
2 check this particular aspect of informed
3 consent because in my experience, surgeons do
4 not typically get into the person's
5 expectancies, their social and psychological
6 expectancies, postsurgery and that is an
7 important part of decision-making. If I have
8 a surgeon or a team of folks who are
9 knowledgeable about that and do undertake
10 that practice regularly, I think it probably
11 could be done by somebody who's not a mental
12 health professional, but generally speaking,
13 in practice, I don't see them doing much of
14 that.

15 Q. All right. So you applied several tests or
16 inventories in your assessment of Kanautica,
17 right?

18 A. Yes. Well, I don't -- I wouldn't say
19 several. It was two.

20 Q. Two. Okay. So let's start with the Trauma
21 Symptom Inventory.

22 A. Okay.

23 Q. I'm sorry. Were you about to say something?

24 A. It's not mine. So I describe it be- -- I
25 didn't -- I didn't administer the Trauma

1 Symptom Inventory.

2 Q. Okay.

3 A. I didn't administer the Beck Depression
4 Inventory or the Beck Anxiety Inventory.

5 Q. Uh-huh.

6 A. Dr. Ettner administered those things.

7 Q. Uh-huh. Okay.

8 A. However, because she did not provide the
9 results or even name what tests they were, in
10 her documents, once I obtained those, I
11 integrated them into my report because they
12 do contain useful information and it is
13 something also that -- Mrs. Zayre-Brown
14 should know the results of the testing.
15 So --

16 Q. You're right. I'm --

17 A. -- to be clear, it wasn't my test
18 administration.

19 Q. Right. That was my mistake. I'm sorry for
20 the confusion. I'd still like to talk about
21 these, though --

22 A. Sure.

23 Q. -- and start with the Trauma Symptom
24 Inventory.

25 What is it?

1 A. The Trauma Symptom Inventory is a self-report
2 inventory. I believe it's 136 items and it
3 is aimed at assessing current trauma
4 symptomology so it's within the last six
5 months. So it's not going to tell us what
6 somebody's trauma symptoms were ten years
7 ago. It's not going to tell us what their
8 trauma symptoms are going to be in two years.
9 It's a snapshot of how they've been doing
10 recently.

11 The measure was developed using adults
12 so it's not appropriate for children, but
13 there are versions for children. It is
14 widely used in the forensic context. It's
15 certainly appropriate for this kind of case
16 and it includes validity scales that tell us
17 not just what the person reported but how
18 they approached the test.

19 Q. All right. And did you review the results of
20 this?

21 A. Yes.

22 Q. And what were the results?

23 A. So the results are described beginning on
24 Page 18 continuing onto Page 19 and
25 concluding at the top of Page 20. The

1 findings of this particular administration --
2 her -- the first thing to say is that her
3 validity scale results were within normal
4 limits meaning that there weren't indications
5 that she's either significantly, like, really
6 strongly denying symptoms that she likely has
7 or that's -- she's exaggerating symptoms
8 either to feign or malingering or as a cry for
9 help. So it doesn't mean that everything
10 in -- that she reported is true or accurate,
11 but we don't have good reason to think that
12 those kinds of factors, significant denial or
13 exaggeration, are reflected in her results.

14 She had one clinical scale elevation
15 and -- it's also important to be clear. When
16 we say clinical, what we actually mean is
17 statistical. So it's just an unusually high
18 elevation compared to the samples of people
19 who are used to develop the test. She had a
20 clinical elevation on the defensive avoidance
21 scale. Defensive avoidance is when a person
22 who's been traumatized undertakes to avoid
23 internal recollections of the stressful
24 events.

25 Q. Uh-huh.

1 A. They don't like thinking about it. They
2 don't like remembering it. But also external
3 avoidance so it might be avoiding talking
4 about their trauma. It might be saying, you
5 know, if I'm going to do this psychological
6 evaluation, I absolutely do not want trauma
7 to be part of that discussion, which is what
8 happened. It's very common because for most
9 of us, if something terrible happens to us,
10 we'd rather not dwell on it, right. So she
11 has an elevation on that.

12 Her -- she had other scores that would
13 be high but weren't statistically unusually
14 high according to the demarcation that the
15 test developers use. So she had -- her
16 post-traumatic stress factor, which is the
17 one that's intended to indicate how closely
18 the person's presentation adhered to the
19 diagnostic criteria for PTSD -- what's the
20 likelihood they have PTSD now? So her score
21 was high but not significantly elevated. So
22 she sort of -- there's a little bit of
23 ambiguity about it. Certainly, she has
24 trauma symptoms, but do they cross the
25 threshold into being diagnosable now is a

1 little bit of a question mark and would need
2 to be explored with more testing to get a
3 definitive answer. She -- but she was at the
4 82nd percentile meaning 82 percent of the
5 other adults in the samples that were used to
6 develop this test had lower scores than that
7 so it's -- it is high.

8 Suicidality was similarly -- like, it
9 wasn't -- it didn't cross a threshold into
10 being statistically elevated, but it's
11 certainly at a level of, you know, probably
12 causing discomfort for her so that's 78th
13 percentile.

14 When we look at the results, there are
15 subscales for the suicidality that showed
16 that she's not reporting suicidal behaviors
17 like attempts or what we call parasuicidal
18 conduct, but she was reporting that she
19 think -- has thoughts about it at times.

20 As I stated in here, the score suggests
21 she has some degree of trauma-related
22 psychological symptomology which may have
23 been below threshold for formal diagnosis and
24 that her results suggested that she had not
25 made suicide attempts or engaged in

1 parasuicidal behavior, which is, like,
2 usually cutting, things like that, in the six
3 months prior to the -- to Dr. Ettner's May
4 2022 TSI-2 administration.

5 Q. Do -- so do these results in any way indicate
6 that gender-affirming surgery would be
7 appropriate or inappropriate for Kanautica?

8 A. No. They're primarily relevant for figuring
9 out if there's potentially other contributors
10 to her distress aside from that and it also
11 helps us identify kind of what are the
12 prominent bothersome features of it for her
13 presently so more just kind of her overall
14 well-being. It does suggest to me that she
15 probably would benefit from her treatment
16 being trauma informed, that there needs to be
17 a sensitivity to that, but it doesn't tell
18 us -- it does not enable us to make a
19 prediction about whether or not having
20 surgery would change these scores.

21 Q. Okay. Anything else about the TSI that you
22 think is important to note for Kanautica?

23 A. No, I don't believe so.

24 Q. Okay. Then let's move on to the Beck Anxiety
25 and Depression Inventories. What are these

1 tests?

2 A. These are very brief tests. They don't take
3 very long. When I was still doing therapy,
4 if I had somebody who had depression or
5 anxiety, they might get -- they might fill
6 one of these out a week for me so they're
7 quick. They are well-regarded tests. They
8 have good psychometric data, but they're also
9 closely correlated. Anxiety and depression
10 are kind of like peas in a pod and it's
11 always been hard for psychologists to really
12 extricate those things. But they're not
13 really deep dives. They are good for getting
14 just a brief snapshot of where somebody's
15 symptoms are, which symptoms are more or less
16 pronounced. And on both of these, the scores
17 that she obtained were not in the normal
18 range. They were elevated, but it was mild
19 elevation.

20 Q. Okay. And so same questions with TSI. Do
21 these results in any way indicate that
22 gender-affirming surgery would be appropriate
23 or inappropriate for Kanautica?

24 A. They could relate to not whether or not the
25 care would be appropriate but what kind of

1 support she might need as she moved through
2 that process. But scores at this level
3 aren't indicative of particularly acute
4 distress and the acute distress could be
5 relevant to either something that you might
6 anticipate an intervention might alleviate or
7 it might be relevant to understanding if
8 somebody might have a temper or a limitation
9 in their capacity to provide informed
10 consent. If they're extremely depressed, for
11 example, they may have trouble thinking
12 clearly and reasoning and that kind of thing.
13 So that's what they could be relevant to, but
14 these results don't suggest that.

15 Q. Okay. So I'm looking at the beginning of the
16 second paragraph in Part B and you say, Given
17 these findings, it appears that
18 trauma-related symptoms are a likely
19 contribute- -- excuse me, likely contributory
20 to her suicidality.

21 Did I read that right eventually?

22 A. Yes.

23 Q. Okay. Can you -- so what is -- what is the
24 basis for this?

25 A. Well, so her presentation during my interview

1 with her, the -- even the correspondence
2 about not wanting to talk about the trauma,
3 that's -- you know, nobody really wants to,
4 but that kind -- that was significant
5 avoidance even before we met. And I can
6 understand wanting to protect your rights and
7 not wanting to say more than you have to say
8 about your personal history, but to me, it's
9 also indicative to some degree of avoidance.

10 And then, you know, she also has these
11 episodes in 2019, 2020, and, I believe, also
12 2021 where she's had really acute distress
13 and had to have kind of crisis care-type
14 intervention. And in my view, it's likely
15 that her trauma history relates to that
16 because it's extremely common for people to
17 have those kinds of issues when they have a
18 significant trauma history especially if it
19 was repeated and it occurred in childhood and
20 it involved a disruption with their rela- --
21 with their caregivers. My understanding is
22 that she was in foster care for a significant
23 amount of time as an adolescent.

24 Q. How do you make a distinction between
25 trauma-related symptoms and gender dysphoria

1 symptoms?

2 A. That's a good question and I do get asked --

3 Q. Thank you. I try.

4 A. I do get asked this, actually, a fair amount.
5 Like I said, I get asked, doesn't trauma
6 cause somebody to become trans somehow? And
7 the fact is, no. The issue is that
8 transgender folks are at significantly
9 increased risk of any number of situations
10 that are likely to result in experiencing
11 traumatic stress or events and then
12 subsequently developing a condition like
13 PTSD. So very high rates of victimization of
14 all kinds, exploitation, high rates of under-
15 and unemployment, high rates of being
16 unhoused, getting kicked out of your house
17 when you're a child because your family
18 rejects you. These are things that are not
19 inherent to being trans. There's nothing
20 about being trans that makes those things
21 okay or natural, but they happen at a
22 disproportionate rate to trans folks and they
23 do cause traumatic stress and injury to them
24 just the same way that they would cause
25 traumatic stress or injury to other people,

1 but they just have an increased risk of
2 encountering those kinds of circumstances.

3 And so it is something that commonly
4 cooccurs. In Ms. -- in Mrs. Zayre-Brown's
5 case she acknowledged that she had a history
6 of significant trauma. In my view, it's not
7 like it's fully explanatory. I -- what I'm
8 not saying is, oh, this is all trauma, the
9 gender dysphoria doesn't have anything to do
10 with this. But what I'm saying is that in
11 terms of significant relief from the -- the
12 suicidality and the distress that she is
13 experiencing, treating the gender dysphoria
14 is really only one piece of the puzzle.
15 There are other things that she's going to
16 need in terms of support and care in order to
17 get significant alleviation of those
18 symptoms.

19 Q. Okay. Anything else about the Beck
20 Inventories that you think are important to
21 know?

22 A. Not that I can think of.

23 Q. Okay. Then let's move on to the Minnesota
24 Multiphasic Personality Inventory, second
25 edition. And you -- you did administer this

1 test --

2 A. Yes.

3 Q. -- correct? Okay. Great. I'll call it the
4 MMPI --

5 A. Yes.

6 Q. -- for brevity sake. What is the MMPI?

7 A. The MMPI is one of our oldest and most widely
8 used psychological inventories. It's broad,
9 it's comprehensive, well researched, commonly
10 used in the forensic setting, has
11 correctional and forensic norms. It's
12 probably the most commonly used psychological
13 test, period, aside from maybe IQ tests if we
14 looked at community as well. It is lengthy,
15 but the 2-RF is called the restructured form.
16 It's actually slightly shorter so I -- I use
17 that to make it less painful and tedious
18 because the full-length version is 567 items.
19 The measure covers a broad range of
20 psychopathology so it covers identity. It
21 covers -- excuse me, like -- I should say
22 self-concept, not identity, interpersonal
23 functioning. It covers be- -- behaviors,
24 mood issues, anxiety issues, somatic issues.
25 I mean, it's got -- it's very, very broad

1 coverage for this measure and it was
2 constructed differently than other
3 psychological tests. It's harder to trick
4 the MMPI or study the MMPI compared to other
5 measures. It -- the nice thing about the
6 MMPI-2-RF, too, is that when you're looking
7 at testing -- doing psychological testing
8 with trans folks, it can be really difficult
9 because of the fact that if somebody is
10 nonbinary, they don't necessarily fit into
11 either of the gender norm groups and the
12 tests that were used to develop some of these
13 measures, they didn't ask people if they were
14 trans or not and so we don't necessarily know
15 if they have different results or the test
16 might work differently for them.

17 So the reason I chose the MMPI is
18 because it doesn't -- 2-RF does not use
19 gender norms, which is, to my way of
20 thinking, the best solution and also
21 consistent with the guidance that we see in
22 the literature on this topic.

23 Like the TSI, the MMPI contains embedded
24 validity scales that tell us how the person
25 approached the measure. Those validity

1 scales are not all created equal. Some of
2 them work better than others, but her
3 validity scale results were within normal
4 limits, again, consistent with the Trauma
5 Symptom Inventory that she wasn't faking or
6 exaggerating things or -- or engaging in a
7 significant amount of what we call faking
8 good, which is pretending to be more virtuous
9 and problem free than you really are.

10 As far as her results go, they're
11 detailed in my report on Page 24. I provide
12 T-scores there, but, you know, we're looking
13 at scores -- 65 or greater, again,
14 statistically significant. You could have a
15 score that's lower than that that's still
16 very bothersome to you. It doesn't mean it's
17 not important if it's below that score. But
18 she had some -- she had several elevations on
19 this scale -- or on this measure, I should
20 say, including externalizing dysfunction,
21 cynicism, antisocial behavior, ideas of
22 persecution, aberrant experiences, hypomanic
23 activation. She had some mild elevation on a
24 scale that reflected suicidality, high --
25 high stress and worry and specific fears.

1 So with the MMPI we don't just talk
2 about individual scale results. We -- we
3 integrate them and we talk about how these
4 things would work together and present in an
5 individual. And so for people who have this
6 combination of results, I provide a narrative
7 that starts at the bottom of Page 24,
8 continues on to Page 25, and ends before the
9 discussion about the Personality Inventory
10 that starts at the bottom of Page 25. So I
11 discuss a little bit more about the
12 suicidality and the relationship between
13 impulsivity and suicidality for her that -- I
14 also just provide a little bit of context
15 that it's not uncommon for incarcerated
16 individuals to have elevated risk factors for
17 suicidality and experience more of that.

18 The narrative part of it is, you know --
19 individuals who have this combination of
20 results tend to describe a lot of frequent,
21 intense, and ruminative worry. They preo- --
22 preoccupy themselves worrying about things.
23 They're vulnerable to stress, which means --
24 I talked about her being like a cork on the
25 ocean, that, like, when stress happens, your

1 mood can drop very quickly and dramatically
2 more so than a typical person.

3 She has also some indications of
4 hypomania which could mean bipolar. I did
5 not diagnose that. I do think she deserves
6 to know that that did come up on the testing
7 and it's something that she should be mindful
8 about, but it wasn't present to such a degree
9 and she didn't present during the interview
10 with me in a way that would cause me to think
11 she was psychotic or something like that at
12 that time.

13 She had some persecutory ideation. That
14 doesn't sound good, but it's actually pretty
15 normal in a carceral setting. You're worried
16 that people are out to get you. You're
17 probably not wrong. Also, I contextualized
18 that finding given the circumstance of her
19 litigation. The remainder of the findings
20 are described in detail in the report and I
21 don't want to belabor it since you have the
22 report.

23 Q. Sure. Okay. So let me back up a little bit.

24 A. Uh-huh.

25 Q. And I'd like -- I'm curious to know more

1 about the -- the test itself.

2 A. Uh-huh.

3 Q. So I could probably parse this out from your
4 last answer, but what does this test measure?

5 A. A very broad variety of what we call
6 psychopathology.

7 Q. Okay. And what is psychopathology?

8 A. Things that can go wrong with your mental
9 health.

10 Q. Okay. And why did you have Kanautica
11 specifically take it?

12 MR. RODRIGUEZ: Asked and answered, but
13 you can answer.

14 A. Well, the instruments -- the tests that
15 Dr. Ettner had done were not, you know, these
16 kind of more comprehensive, sort of omnibus
17 almost style instrument. They were more
18 narrowly focused and, you know, as I actually
19 heard in one of your questions, like, not all
20 that relevant really in some respects
21 ultimately given the findings.

22 The MMPI doesn't tell us if somebody is
23 trans or not. It doesn't even tell us if
24 they have gender dysphoria or not. It's not
25 a diagnostic instrument for that. It look --

1 it's more -- the aim of this is more to look
2 at cooccurring conditions that the person
3 might have and also what their strengths and
4 challenges are in terms of personality and
5 their interpersonal functioning because that
6 can be relevant for treatment planning and
7 capacity to provide informed consent.

8 Q. Do you know who created the test?

9 A. Yes. So it was created at -- well, it was --
10 it was a couple of different people.

11 Q. Uh-huh.

12 A. Ben-Porath is the person who publishes the
13 most now about the MMPI, but it was created
14 at a hospital in Minnesota. Many, many, many
15 people completed earlier versions of the
16 measure and, like I said, it was created very
17 differently from a lot of other psychological
18 tests but in, I think, a good way. It's
19 called an atheoretical test development.

20 Q. Do you know if the test was created for a
21 specific purpose?

22 A. Well, originally, I'm not sure if they were
23 thinking of using it internally, but, I mean,
24 it was developed as a psychological test for
25 fairly broad use. Now, they have updated the

1 instrument over time. They've expanded the
2 norms to be more representative of the
3 population, but it's not appropriate for
4 everybody. There are -- there are limits to
5 it. The reading level, for example, can be
6 too high for some individuals so it's not a
7 test that is for everybody. I certainly
8 don't want to make it seem like everybody
9 should have an MMPI no matter what they come
10 in for, that they're all suitable for it.
11 But it was commonly used in the forensic
12 setting not only because it gives you such
13 broad coverage but also because it includes
14 these validity scales and in forensic
15 settings, you want to be able to offer some
16 amount of, you know, I investigated whether
17 or not this person was providing a forthright
18 or accurate report with the information that
19 I have. Measures like the MMPI permit you to
20 do that.

21 Q. Okay. And so is this a diagnostic tool?

22 A. It's a diagnostic tool, but you can't rely on
23 it solely for the purpose of diagnosis.

24 Q. Okay. Is it also used for assessing a
25 patient's need for a specific treatment?

1 A. It could be. So, for example, if someone
2 elevated on the depression scale and that was
3 very, very high elevation and they elevate
4 on -- you know, they produce a pattern of
5 results consistent, for example, with
6 borderline personality disorder, that tells
7 us probably this person should have
8 dialectical behavior therapy. Does the test
9 output say, dialectical behavior therapy?
10 No. But it does tell you what the picture is
11 of their symptoms and then you can identify
12 the best fit in terms of treatment after
13 that.

14 Q. Okay. Did you have Kanautica take the MMPI
15 for the purpose of assessing her need for a
16 treatment?

17 A. So not so much for her need for the treatment
18 but to get a -- an updated picture of what
19 her current symptoms are, the severity of
20 those symptoms, and then to be able to
21 ascertain how that might interface with the
22 likely benefit that she would receive from
23 gender-affirming care, under what
24 circumstances, and also if there was any need
25 for active management of cooccurring

1 conditions that could interfere with either
2 her ability to provide informed consent or
3 her ability to benefit in the longer term
4 from the procedure.

5 Q. Have you used this test with any other
6 patients to assess a need for
7 gender-affirming care?

8 A. Oh, I've given -- yeah, I've given MMPIs as
9 part of that process, but it's not a
10 situation where the MMPI gives me an answer
11 as far as, A, whether or not the person needs
12 gender-affirming care at all and it also
13 doesn't tell me if they do, what it -- what
14 specifically procedure or interventionwise
15 that they need and that's a big universe.
16 You know, it can be everything from voice
17 training to your underwear to surgery. It's
18 a spectrum.

19 Q. Uh-huh.

20 MR. SIEGEL: Okay. Can we go off the
21 record for a moment?

22 (Discussion off the record.)

23 (Whereupon, there was a lunch recess in
24 the proceedings from 12:06 p.m. to 12:44
25 p.m.)

1 BY MR. SIEGEL:

2 Q. All right. Back on the record. Dr. Boyd,
3 welcome back. Hope you were able to get
4 something to eat. Before we move on to the
5 next subject, one follow-up question.

6 A. Sure.

7 Q. I believe you said that you had -- there
8 might be some concerns about complications
9 resulting from vulvoplasty.

10 A. Uh-huh.

11 Q. Do you have a sense of how common
12 complications are from that procedure?

13 A. I don't know. What I would typically suggest
14 is -- well, first of all, I would say that's
15 for a -- the medical provider to talk about
16 for Mrs. Zay- -- Zayre-Brown. Given her
17 history, her collection of symptoms, her
18 presentation, what would be most helpful
19 would be to have an individualized prediction
20 about that.

21 Q. Okay.

22 A. And probably contingent on setting, too. So
23 give one opinion about risks in carceral
24 environment and another one in the community.

25 Q. Okay. Got it. All right. Then looking back

1 to your report, I'm looking at Page 24.

2 A. Yes.

3 Q. And looking at the last sentence in the
4 second paragraph you write, In other words,
5 gender dysphoria is not necessarily the
6 primary and direct cause of
7 Mrs. Zayre-Brown's suicidality and urgent
8 surgical treatment for her gender dysphoria
9 will not necessarily reduce or eliminate her
10 risk of having suicidal ideation in the
11 future.

12 Did I get all that right?

13 A. Yes.

14 Q. Okay. Are you providing an opinion that
15 something other than gender dysphoria is the
16 primary and direct cause of her suicidality?

17 A. No. I would say there are multiple
18 contributors and I don't think one could be
19 identified as the primary cause.

20 Q. Okay. And what are the other contributors in
21 your view?

22 A. So certainly, one is the -- the carceral
23 status. You know, people who are
24 incarcerated have roughly ten times the rate
25 of completed suicide regardless of their

1 gen- -- actually, cisgender women have a
2 slightly higher rate of completed suicide,
3 ten times the rate of the general population.
4 So the carceral status is one variable there.

5 Another one is, excuse me, that she does
6 have -- she does have trauma symptoms and I
7 do think those are contributing, but I also
8 would not say that if you treated -- if -- if
9 she is released from prison and she treats
10 her trauma symptoms that that means the
11 suicidality would go away. I don't think --
12 I think she needs intervention for all of the
13 contributors.

14 Q. Okay. So you think that her gender dysphoria
15 is a contributor to her suicidality; is that
16 right?

17 A. Yes.

18 Q. Okay. And you're -- but you're not saying
19 to -- you know, that's, like, 20 percent or
20 50 percent or whatever, are you?

21 A. I don't think it's possible to extricate it
22 and provide a -- an opinion that would be
23 that precise. So, you know, it could be 5
24 percent. You know, I -- I don't think it's
25 possible -- I think it would be misleading to

1 offer a number.

2 Q. Uh-huh. Okay. So since -- since that is
3 a -- a contributor in your view, if
4 Mrs. Zayre-Brown were to undergo surgery,
5 would that at least reduce her risk -- or
6 would that reduce her levels of suicidality?

7 A. I think it depends. It depends on what --
8 how it's performed, under what conditions
9 with what amount of social support. And
10 that's consistent, again, with -- going back
11 to the -- the declar- -- summary of the
12 findings from the Cornell study. I mean,
13 that's consistent with what is also
14 demonstrated in that research literature.

15 Q. Okay. If it is performed in a carceral
16 setting, do you believe that would reduce her
17 suicidality?

18 A. I think that if she -- I think that her
19 finding out that she has a date when she
20 knows that she will be able to get her
21 surgery done -- I think that will improve her
22 suicidality whether she's incarcerated or in
23 the community. So I think there's different
24 kind -- and then getting the procedure itself
25 will offer a different -- will have

1 additional benefit. I think at each step of
2 the way -- depending on where she's located,
3 each movement toward that process will likely
4 offer her a psychological benefit both
5 broadly speaking in terms of her mood
6 because, like I said, she's like a cork on
7 the ocean so good news will also lift her
8 mood --

9 Q. Uh-huh.

10 A. -- but also, at the same time, it's not a
11 solution. It's not going to make it go away
12 and there are other things that could make
13 her suicide risk fluctuate acutely. Even if
14 somehow we could wave a magic wand and the
15 gender dysphoria went away completely, that
16 would still be a concern and would need
17 active management.

18 Q. Okay. You mentioned additional benefits.
19 What would those be?

20 A. I'm sorry. Do -- can you remind me --

21 Q. I -- I -- I think you said that if she were
22 to undergo surgery, aside from suicidality
23 there would be additional benefits. If
24 that's not what you said or meant, please
25 correct me, but that's what I heard.

1 A. Oh, well -- so, I mean, gender dy- --
2 dysphoria, it can -- it can be associated
3 with suicidality, but it's associated with
4 other things, too. And when I say benefits,
5 I actually also mean, like, positive things,
6 not just relief of negative experiences.

7 So, for example, she indicated that
8 one of -- the -- some of the things she'd
9 like to do involve sports and, like, dancing,
10 things like that that she feels she can't --
11 in her deposition she talked about this a
12 fair amount, that there are things she feels
13 she cannot do because she hasn't had that
14 bottom half surgery yet. That -- those
15 benefits are significantly more relevant and
16 accessible to her in a community than they're
17 going to be in a carceral setting based on
18 her own reasoning and her -- and her own
19 statements about that. So that's what I mean
20 when I say it could be different.

21 Q. Got it. All right. I'd like to turn to Page
22 34, please. And this is Conclusion Number 2,
23 A clinical psychologist cannot reasonably
24 predict with confidence that a particular
25 intervention will be curative of a condition

1 such as gender dysphoria, which has a diverse
2 manifestation and is inextricably bound up in
3 aspects of the person's life and
4 circumstances that go far beyond the physical
5 appearance of their genitals.

6 Did I read that right?

7 A. Yes.

8 Q. All right. So big picture question. Like,
9 can gender dysphoria be cured?

10 A. I think there are certainly people who could
11 get to the point that they would be
12 subthreshold, right. That's an -- I -- I've
13 talked before about how there's difference
14 between subthreshold and having no symptoms.
15 I think certainly for most people, there's
16 the possibility of bringing somebody
17 subthreshold for gender dysphoria, but it's
18 usually not the case that there's a single
19 intervention that's sort of like a magic
20 bullet. It's usually a combination of things
21 that deal with, you know, as I allude to
22 here, not just what their genitals look like
23 or their secondary sex characteristics but
24 also what their social environment is, what
25 their supports are --

1 Q. Uh-huh.

2 A. -- what their access to care -- all kinds of
3 care is.

4 Q. Okay. So why is it that a -- a psychologist
5 can't predict that a certain intervention
6 will be curative of gender dysphoria?

7 A. Because of the fact that it -- there's so --
8 there's other contributing causes. I mean,
9 like, really just what I said there. It's
10 not just about the -- the appearance of
11 somebody's physical body. There are other
12 factors there. So it's more like I'm saying
13 there's not one thing most of the time. And
14 for her specifically -- getting into her
15 specifics, she articulates repeatedly that
16 there are other factors that contribute
17 significantly to her gender dysphoria,
18 specifically transphobia that she encounters
19 from other people and also to some degree, I
20 think, internalized transphobia when she
21 feels that she's been recognized and
22 identified and then treated differently
23 because she's a trans woman.

24 Q. In your view, can a psychologist predict with
25 confidence that a certain intervention

1 wouldn't be curative but that -- but that
2 it's necessary to achieving a cure?

3 MR. RODRIGUEZ: Objection to form. You
4 can answer it.

5 A. We would call that necessary but not
6 sufficient --

7 Q. Uh-huh.

8 A. -- in -- in our terminology. So it's a piece
9 of it, but it's not going to get you all the
10 way there is the idea. That's one way of
11 looking at that, yeah.

12 Q. Okay. Would that be true for any clinical
13 psychologist?

14 A. I'm sorry. I -- can you ask that question in
15 a different way?

16 Q. Would it be true for any clinical
17 psychologist --

18 A. That --

19 Q. -- that you cannot predict that a certain
20 intervention will be curative?

21 A. I think it depends on the intervention and it
22 depends on the individual.

23 Q. Okay. Well, how -- how about yourself, would
24 that apply to you?

25 A. Well, yes. I mean, I think it would depend.

1 If I have somebody that it's a very
2 straightforward presentation and they --
3 let's say they have very physiological
4 depression symptoms, in other words, they
5 feel very tired, they have very little
6 motivation, they can't -- just can't move
7 their body to do the things that they need to
8 do. Provided that there isn't an underlying
9 medical condition and that's been ruled out
10 through interdini- -- disciplinary practice
11 or referral, then I would say we have good
12 reason to believe that probably about 80
13 percent of people would achieve remission is
14 what we would call it for -- for a condition
15 like that. So I could tell -- I wouldn't
16 tell somebody, I'm absolutely confident this
17 will cure you.

18 Q. Uh-huh.

19 A. You know, something else could happen. Their
20 parent could die. They -- you know, any
21 number of things could happen that could
22 interfere with their progress, you know, but
23 I could say, you know, given the evidence
24 base for the success rate of this
25 intervention, given the complexity or lack of

1 complexity in your presentation, you know,
2 here's how likely I think it is you would
3 benefit, but I would never tell somebody, I
4 am certain that this will cure you.

5 Q. Okay. Let's flip to Page 20. So I'm going
6 to -- the last sentence of Subsection B you
7 say, Likewise, surgical intervention alone is
8 not likely to be curative and may not
9 substantially ameliorate her suicidality --

10 A. Uh-huh.

11 Q. -- is that right?

12 A. Right.

13 Q. Okay. So are you making a prediction here
14 about whether a certain treatment would be
15 curative?

16 A. I think it's not likely it would be curative.
17 I do -- I think it's likely she would achieve
18 a benefit from it. It's really -- I think
19 the debate is sort of the degree of that
20 benefit. Secondarily, you know, the question
21 of, like, substantially ameliorating her
22 suicidality, I mean, it might, you know, but
23 I don't think that we have confidence to say
24 it will.

25 Q. Do you see any tension between your assertion

1 here and the assertion we spoke about a
2 moment ago that a psychologist cannot predict
3 with confidence that a certain treatment will
4 be curative?

5 A. Yes, but that's basically making -- that's
6 saying, this is -- this is how this is going
7 to go. What I -- what I'm saying instead
8 here when I'm saying it's not likely to be
9 curative is -- what I'm saying is the most
10 likely outcome is that it's going to fall
11 short of that particular benchmark of being
12 curative. Doesn't mean -- I'm not saying
13 surgical intervention alone is not likely to
14 provide psychological benefit or amelioration
15 of the symptoms, but it's not -- I don't
16 think it's likely to be curative
17 specifically. That's a very high bar.

18 Q. Okay. But do you think that gender-affirming
19 surgery would provide psychological benefit
20 to Kanautica?

21 A. I think depending on the circumstances, if
22 it's provided in the way that she details,
23 which I described in my report on Page 31,
24 receiving medical care in the community
25 including aftercare and wound management,

1 receiving care and support directly from her
2 support network, participating in meaningful
3 personal and professional development
4 opportunities both while she's preparing for
5 it and while she's recovering from it, then,
6 yeah, I think she -- I have no problem at all
7 saying I think it's likely she would benefit
8 from that and probably, I think, get
9 significant relief both with respect to
10 gender dysphoria and with respect to
11 suicidality.

12 Q. Okay. Are you familiar with the treatments
13 for gender dysphoria she has received so far?

14 A. I don't want to misrepresent my level of
15 understanding. I have some understanding of
16 what she's already undertaken, but I don't
17 have a medical professional's level of
18 knowledge.

19 Q. Okay. Do you know that she has been on
20 hormone therapy?

21 A. Yes.

22 Q. Okay. Do you know that she has un- --
23 undergone social transitioning?

24 A. Yes.

25 Q. Okay. To your knowledge, have those

1 treatments cured her of gender dysphoria?

2 A. No.

3 Q. Okay. Other than surgery, is there any
4 treatment that you're familiar with for
5 gender dysphoria that she has not received?

6 A. So medical treatments, I couldn't speak
7 comprehensively to that because I'm not a
8 medical expert so I can't tell you what all
9 of those options would be. I don't believe
10 that she's done voice training. That's
11 something that she could do. There might be
12 other kinds of sort of plastic surgery-type
13 interventions that she might want, but, you
14 know, those are -- you know, the -- the
15 surgery aspects are a medical intervention.
16 And additionally, there -- this is such an
17 evolving area of practice that there are new
18 procedures all the time so the options today
19 might not be the options next year. There
20 could be other things that would help her.

21 She had -- she -- and she has had
22 plastic surgery from what I understand in
23 terms of what I discussed with her in her
24 deposition, but when you read her description
25 of it and talked with her about it, she

1 describes getting very, very limited gains
2 from these prior medical interventions.

3 Now, you know, one of the questions
4 would be if she got such limited benefit from
5 the prior interventions, why do we believe
6 we're going to make the jump to a hundred
7 with the -- one single intervention, you
8 know? I don't think there's a -- I don't
9 think we have good reason to believe that
10 based on her own characterization and
11 recollection of her experiences with medical
12 intervention.

13 Q. Uh-huh. So zooming out somewhat, like, big
14 picture, what do you believe is causing her
15 gender dysphoria?

16 A. So Mrs. Zayre-Brown has had a very -- from my
17 understanding she has not had an easy life.
18 She does have support in her marital
19 relationship and evidently her family
20 relationships, but living as a transgender
21 person in the United States at this point in
22 time is painful and difficult not only
23 because of constraints on access to services
24 or people not even knowing what's available
25 to them sometimes or not being able to afford

1 it, but also, obviously, there's a cultural
2 environment that's hostile to people and I
3 believe that that cultural environment is a
4 significant cause and contributor to her
5 gender dysphoria.

6 On top of that, frankly, our gender
7 binary is -- is highly, highly determined by
8 essentially the -- the ancestry's eugenics
9 and the beauty standards for women are
10 difficult for anybody to achieve and fairly
11 narrow. And I think if the aim is to not be
12 identifiable as a trans woman, that's going
13 to -- that's difficult. And if you are
14 identified, then it may be because of some
15 piece of your anatomy that somebody knows
16 about, but it could also be your height. It
17 could be your shoulders. It could be your
18 voice. People who aren't even trans are
19 getting -- people are telling them that
20 they're trans because their shoulders are too
21 broad or their voice is too low. There are
22 all kinds of ways in which she, I think,
23 experiences transphobia in ways that have,
24 frankly, nothing to do with her primary sex
25 characteristics, but I also believe that

1 there is a contribution that is coming from
2 her own internal discomfort with continuing
3 to have a phallus when that is not consistent
4 with her gender identity. I do think that
5 contributes to her gender dysphoria and it
6 makes sense then rationally that coping with
7 that is going to be a sensible step for her
8 in terms of treatment.

9 Q. And to be clear, what do you mean by coping
10 with that?

11 A. Well, I mean having -- having a procedure
12 to -- you know, having bottom half surgery,
13 whether that's a vulvoplasty or vaginoplasty,
14 dealing with that component of it, of the
15 internalized transphobia. And also, just the
16 discomfort, emotional and psychological
17 discomfort, with continuing to have a
18 phallus, that is its own contribution. I
19 think that's valid. I believe her when she
20 says that.

21 Q. Do you have any reason to think that
22 Mrs. Zayre-Brown can be cured of her gender
23 dysphoria while she still has a penis or a
24 phallus as she calls it?

25 A. Based on her statements, I think not. I

1 believe her self-report has consistently been
2 that this is something that she sees as sort
3 of a keystone intervention. I think the main
4 difference really is just that in my view,
5 she needs other things as well and that we
6 want to be careful and mindful about the
7 timing and the setting and the context of
8 intervention to maximize the benefit that
9 she's going to get so we can get as close to
10 the benefit as she anticipates as we possibly
11 can.

12 Q. Okay. You mentioned the -- the phrase
13 necessary but not sufficient a little while
14 ago.

15 Would you say that removing her phallus
16 and having genital surgery would be necessary
17 but not necessarily sufficient to cure her
18 gender dysphoria?

19 A. Ultimately, yes. The question of the timing,
20 I think, is a separate issue, but in the
21 long-term sense, yes.

22 Q. Uh-huh. Did you find any contraindications
23 for surgery?

24 A. So I can't speak to medical contraindications
25 for surgery. And surgery, broadly speaking,

1 no, but as far as what she described -- you
2 know, that's what I keep coming back to is
3 what she's describing as the set of
4 circumstances that are going to -- going to
5 give her the most relief.

6 Q. Do you have any reason to think that if she
7 underwent a vulvoplasty, she would later
8 regret it?

9 A. I think it's possible if the -- not in and of
10 its- -- not, like, per se. Not only because
11 of, oh, I wish I had had another procedure.
12 It's possible depending how -- how the
13 procedure went that later on, she could have
14 some amount of regret, not that she had a
15 vulvoplasty but that she didn't have a
16 vaginoplasty instead. I think that's
17 possible. I don't think it's likely that she
18 would experience regret in terms of saying, I
19 wish I still had a phallus.

20 Q. If someone undergoes a vulvoplasty, are they
21 able to also undergo vaginoplasty later?

22 A. My understanding of it -- and I want to be
23 clear because I'm not a medical professional.
24 I can't give a medical opinion. But my
25 in- -- understanding from consulting with

1 medical professionals who do the procedures
2 is that vulvoplasty is a less commonly done
3 procedure so it's -- most of the surgeons who
4 would do it will have less familiarity with
5 doing that compared to vaginoplasty and also
6 that with respect to both the orchiectomy and
7 vulvoplasty, there's the necessity of
8 maintaining a certain amount of tissue and
9 certain structures in order to be able to
10 later do a vaginoplasty, although there are
11 alternative procedures that can be done if
12 that tissue isn't there, and they may be more
13 or less desirable to the individual. I think
14 it has to be a highly individualized medical
15 decision that's made between the doctor and
16 their patient.

17 Q. Okay. Let's turn to Page 29 of your report,
18 please. And I'm -- it's the final sentence
19 of the third paragraph on the page. In other
20 words, Mrs. Zayre-Brown's acute mental health
21 crises in recent years were indirectly rather
22 than directly related to her gender
23 dysphoria. Additionally, by her account,
24 significant contributions to her distress
25 were associated with administrative processes

1 and delays related to her treatment.

2 Did I read all that correctly?

3 A. Yes.

4 Q. What does it mean for something to be
5 indirectly related to gender dysphoria?

6 A. So the idea would be that there's a certain
7 amount of distress that comes from what I
8 just described as this sort of
9 compartmentalized -- it may be internalized
10 transphobia or may be some other
11 manifestation of just dis- -- emotional and
12 psychological discomfort with continuing to
13 have a body part that you don't want to have
14 or wishing you had one that you don't. The
15 mental health crises appear to be in part --
16 again, it's like that cork on the ocean
17 thing. The gender dysphoria is going to
18 be -- I think for her it has ebbed and flowed
19 to some degree, but I don't think there's a
20 time when it hasn't been present as far as I
21 can tell. But the interactions with
22 authority figures who give her bad news, who
23 she perceives as delaying things, or when she
24 has feelings of abandonment, that also taps
25 into, I think, some trauma-related issues

1 that get at abandonment and rejection and I
2 think that also triggers these acute mental
3 health crises, which doesn't mean that, oh,
4 you just solve the trauma problems and you
5 won't have any more of those acute mental
6 health crises. All it means is that we need
7 to have an integrated care/treatment plan
8 that accounts for both the gender dysphoria
9 and what's needed for that but also managing
10 the mood symptoms and the trauma symptoms.

11 Q. And when you say delays here, what delays are
12 you referring to?

13 A. So this is -- you know, it says, by her
14 account.

15 Q. Uh-huh.

16 A. So this is -- what she's telling me is that
17 she felt that there were times that she
18 wasn't getting enough information about what
19 the status was of things that were happening,
20 that it took too long to schedule
21 consultations or even find out whether one
22 would be scheduled, that she would get
23 anxious waiting for decisions to come in. So
24 these are things that she was telling me were
25 the source of distress for her.

1 Q. Okay. Do you believe that those delays
2 happened?

3 A. I don't have any reason to think that her
4 subjective perspect- -- perspective as
5 related to me is not accurate. I don't think
6 she misrepresented her perspective. Whether
7 or not it's objectively true that there were
8 delays I can't speak to because those are
9 administrative processes and I don't know if
10 they, you know, occurred in a -- according to
11 some set of time lines that they were
12 supposed to abide by.

13 Q. Okay. But you don't have any reason to not
14 believe Kanautica that those delays happened?

15 A. I believe that from Kanautica's perspective,
16 it has absolutely been a process that has
17 been marked by delay and disappointment.

18 Q. Right. My question is more in terms of
19 whatever objectively happened.

20 A. Uh-huh.

21 Q. Do you have any reason to believe that
22 something other than what Kanautica told you
23 happened?

24 A. Oh, no.

25 Q. Okay. Do you believe that those delays

1 caused her distress?

2 A. So it's hard to differentiate between the
3 delays themselves and getting news about
4 things because when you look at the pattern
5 for her, it does appear that when she's
6 having the more acute distress, it's not
7 after some long period of time has gone by.
8 It's more like she got news from somebody is
9 often -- she described in her interview with
10 me, for example -- I think it was Dr. Hahn
11 came and told her bad news and so it wasn't
12 just that she had waited. It wasn't the
13 delay. It was the -- from her perspective
14 getting this news and also feeling
15 unsupported afterwards. Same thing, I think,
16 when she had to go to the hospital and then
17 she came back and she had to go into
18 restrictive housing.

19 So some of that is certainly distress
20 about getting news that she didn't want,
21 feeling disappointed and hopeless, I think,
22 but also, she was distressed as well about
23 having to return and then go into restrictive
24 housing.

25 Q. And the distress that she experienced, is

1 that because she would continue to have a
2 phallus?

3 A. I think some of it is -- yeah, I think that's
4 absolutely part of it for her. I just don't
5 think it's a hundred percent of it.

6 Q. Okay. All right. Let's turn back to Page
7 34, please. All right. I'm looking at
8 Conclusion Number 3. My evaluation of
9 Mrs. Zayre-Brown did not reveal any
10 significant findings in her mental state that
11 would counsel in favor of the surgery as an
12 immediate intervention to be conducted in a
13 prison setting from a psychological
14 standpoint.

15 Did I get all that right?

16 A. Yes.

17 Q. Okay. What do you mean by immediate
18 intervention?

19 A. I would say as sort of like a -- something
20 that needs to happen in the next couple of
21 months in that setting given her set of
22 circumstances. Now, that's separate from the
23 question of whether she'll benefit from it.
24 I think she would benefit from it, but in
25 terms of it needing to be an acute -- an

1 immediate intervention, we would typically be
2 thinking of that as more of an acri- -- a
3 crisis -- active crisis situation.

4 Q. Okay. Is there a time frame that you have in
5 mind that would be more appropriate than --
6 well, let me rephrase that question.

7 Did you have -- make any findings that
8 would counsel in favor of the surgery, you
9 know, if not a couple months from now, then,
10 I don't know, three or four months from now?

11 MR. RODRIGUEZ: I'm going to object to
12 the form. You can answer.

13 A. So this is -- you know, if you read the
14 sentence it says, an immediate intervention
15 to be conducted in a prison setting from a
16 psychological standpoint. So that's given
17 that she's going to continue to remain
18 incarcerated. So it's that particular set of
19 in- -- of circumstances. So in -- in a
20 prison setting immediately, like, in the next
21 couple of months, three months, four months,
22 that would still be fairly immediate because
23 there's a period of preparation she'll have
24 to undertake. She -- she couldn't have it
25 tomorrow. You know, she would have -- she

1 has a certain amount of preparation she would
2 have to undertake anyway. But what she
3 indicated when I interviewed her is that
4 simply knowing either that she's going to
5 have surgery and it's scheduled -- and she
6 didn't give a time frame for that. She
7 didn't say within the next year. She just
8 said scheduled. And then also the issue of,
9 you know, having a plan for the reentry
10 program that she wanted to enter into. She
11 indicated that those things would really
12 significantly alleviate her distress and so
13 based on her account, that pushes back
14 against the notion that it needs to be
15 immediate. What she's telling us is that
16 there are other things that we can do now
17 that would give her significant relief, plans
18 that we can make, you know, placements that
19 she could go to potentially based on her
20 account but that those are the kinds of
21 things that are going to factor into how
22 she's feeling.

23 So, in other words, it's not getting the
24 surgery. It's having a future where she sees
25 herself being able to get the surgery that

1 she wants. And the future that she describes
2 as being best for her and most
3 psychologically beneficial for her is the one
4 that -- I mean, I don't want to be redundant,
5 but we've already gone over it a couple of
6 times in the report.

7 Q. So if Kanautica were out in the community
8 right now and you were treating her as -- as
9 your patient, would you recommend immediate
10 surgery?

11 A. I don't know. I mean, she would have -- I'd
12 have to evaluate her. You know, the other
13 thing is that there is a -- the reentry is
14 not stress free for people. Even though it's
15 a positive event, it's also highly stressful.
16 So, you know, I think she's anticipating it
17 in a positive way. I think ultimately,
18 she'll have significant positive mental
19 health benefits from release, but I think
20 she'll also -- you know, when I assessed her
21 she was in prison and I think she would
22 probably just need a follow-up. I would give
23 her a couple of weeks to -- to adjust so that
24 the assessment wasn't looking at just, like,
25 a -- you know, sort of disorientation from

1 reentering the community, but she also hasn't
2 been locked up for that long so I think that
3 could probably be a pretty brief discussion
4 with her just to make sure that her mood is
5 okay is the primary thing, that that's not
6 dysregulated in some way. But as far as in
7 the community, I don't see any reason why she
8 wouldn't be suitable for surgery in whatever
9 time frame she and her treating providers
10 deemed appropriate.

11 Q. Okay. And in your view, is it her being
12 incarcerated that makes her unsuitable or
13 less suitable for surgery now?

14 MR. RODRIGUEZ: Objection to form. You
15 can answer.

16 A. It's not the incarceration so much as the
17 timing. So she is due for release in a
18 relatively short amount of time. And it's
19 relevant also specifically with respect to
20 the suicidality benefit because people who
21 have less than 18 months left to serve on
22 their sentence -- that's kind of the dividing
23 line. If you look at the research on suicide
24 in incarcerated folks, people who have less
25 than 18 months, then you see a decrease in

1 their suicide risk. 18 months forward you
2 have a -- what we call a dose-dependent
3 effect where the more time they have to
4 serve, the more suicidal they -- more likely
5 it is that they'll die by suicide.

6 So for her, it is an issue of timing in
7 the fact that she doesn't have a lot of time
8 left. If she did have a lot of time left,
9 her mental state might also be different if
10 she wasn't anticipating release, you know, so
11 I think it's hard to sort of forecast how she
12 might look different if she had more time
13 ahead of her.

14 Q. Do you know if there's any risk in delaying
15 gender-affirming care for someone with gender
16 dysphoria?

17 A. Yes, I mean, absolutely. But
18 gender-affirming care is a very broad
19 category. Gender-affirming care can be using
20 somebody's name.

21 Q. Okay. Well, then I'll be more specific.
22 Gender-affirming surgery. If someone is a
23 candidate for gender-affirming surgery, is
24 there -- specifically genital surgery, is
25 there any risk in delaying that treatment?

1 MR. RODRIGUEZ: I'm going to object,
2 vague, but you can answer.

3 A. There are some individuals who I think would
4 be harmed by that, yes, but I also think it
5 has to be an individualized determination.

6 Q. And what kind of person would be harmed by
7 that?

8 A. So this gets -- this is a difficult kind of
9 question to answer because I think that there
10 are a lot of circumstances about
11 institutional environments that put trans
12 people in a difficult position. If you say,
13 well, it's the people who are attempting
14 autocastration or autopenectomy, then what
15 that does is that incentivizes people to feel
16 like that's something I need to do in order
17 to be able to get care so I'm always very
18 cautious about talking about that. But
19 certainly, people who are actively
20 self-mutilating, self-injuring, or making
21 attempts, which, you know, the -- that's
22 concerning. The issue is always going to be,
23 though, how much benefit are they going to
24 get from purely the surgical intervention
25 versus a full treatment plan that encompasses

1 other components of whatever it is that
2 they're dealing with because, like I said,
3 most trans people, they have other things
4 going on in their life that are -- you know,
5 trauma in particular is so common that --
6 and -- and they're also at high risk in -- in
7 carceral facilities. You know, PREA
8 acknowledges that. So, you know, it's
9 complicated and make -- does make it very
10 difficult to answer these hypotheticals for
11 that reason.

12 Q. Uh-huh. Okay. So I understand, and correct
13 me if I'm wrong, but that in your view,
14 undergoing surgery while she's in prison
15 would be far from ideal for Kanautica.

16 Is that fair to say?

17 A. Yes, by her own account.

18 Q. Okay. If she were to undergo a vulvoplasty
19 in prison, do you think it is likely or
20 unlikely that she would receive psychological
21 benefit?

22 A. I think it's likely she would get some degree
23 of psychological benefit. I would definitely
24 fall short of saying it would be curative or
25 something close to curative because I think

1 there are a number of other factors. But
2 would she get some psychological benefit from
3 it? Provided that it went okay and she
4 didn't have significant surgical
5 complications, which is entirely possible and
6 could cause all kinds of issues, then I think
7 she would get some benefit from it. I think
8 that's likely. I think even just finding out
9 that she's going to get the surgery, whe- --
10 you know, in the community or elsewhere, I
11 think that give -- also would give a benefit.

12 Q. Does it give the same benefit?

13 A. In the longer-term sense, likely, no. But in
14 the short-term sense, probably, actually,
15 there wouldn't -- I don't know that there
16 would be that much difference. And, in fact,
17 she might have more stability in terms of the
18 benefit of having something scheduled because
19 of the potential disruption that the medical
20 process itself could cause for her.

21 Q. Okay.

22 MR. SIEGEL: Let's go off the record.

23 (Whereupon, there was a recess in the
24 proceedings from 1:19 p.m. to 1:25 p.m.)

25 MR. SIEGEL: All right. We have no

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more questions at this time.

THE WITNESS: Okay.

MR. RODRIGUEZ: All right.

MR. SIEGEL: Anything?

MR. RODRIGUEZ: No. No, we're good.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 1:25 P.M.]

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A C K N O W L E D G E M E N T O F D E P O N E N T

I, SARA BOYD, PH.D., declare under the penalties of perjury under the State of North Carolina that I have read the foregoing 183 pages, which contain a correct transcription of answers made by me to the question therein recorded, with the exception(s) and/or addition(s) reflected on the correction sheet attached hereto, if any.

Signed this, the _____ day of _____, 2021.

SARA BOYD, PH.D.

State of: _____

County of: _____

Subscribed and sworn to before me this _____ day of _____, 2023.

Notary Public

My commission expires: _____

