UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

JOAQUÍN CARCAÑO ET AL., *Plaintiffs,* v. PATRICK MCCRORY ET AL., *Defendants*.	No. 1:16-cv-236-TDS-JEP

EXPERT DECLARATION OF RANDI ETTNER, Ph.D

PRELIMINARY STATEMENT

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration.

2. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy which is attached as Exhibit A to this declaration. I received my doctorate in psychology from Northwestern University in 1979. I am the chief psychologist at the Chicago Gender Center, a position I have held since 2005.

3. I have expertise working with children, adolescents, and adults with gender dysphoria. I have been involved in the treatment of gender dysphoric individuals since 1977, when I was an intern at Cook County Hospital in Chicago, and in the course of my career, I have evaluated and/or treated between 2,500 to 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

4. I have served as a consultant to multiple school districts in the state of Wisconsin as well as the Chicago public school system on issues related to gender identity. I was selected

as the named honoree of an externally-funded fellowship in recognition of my achievements in the field of transgender health—the University of Minnesota Randi and Fred Ettner Fellowship in Transgender Health—and have been an invited guest at the National Institute of Health to participate in developing a strategic plan to advance the health of sexual and gender minorities.

5. I have published four books, including the medical text entitled "Principles of Transgender Medicine and Surgery" (co-editors Monstrey & Eyler; Routledge, 2007) and its 2nd edition (co-editors Monstrey & Coleman, 2016). I have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I have served as a member of the University of Chicago Gender Board and am a member of the editorial board for the *International Journal of Transgenderism*.

6. I am a member of the Board of Directors of the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin International Gender Dysphoria Association), and an author of the WPATH Standards of Care (7th version), published in 2011. The WPATH-promulgated Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

7. In preparing this declaration, I reviewed the materials listed in the attached Bibliography (Exhibit B). I may rely on those documents, in addition to the documents specifically cited as supportive examples in particular sections of this declaration, as additional support for my opinions. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

8. In the past four years, I have testified as an expert at trial or deposition in the following matters: *Kothmann v. Rosario*, Case No. 5:13-cv-28-Oc-22 PRL (M.D. Fla.); and *Doe v. Clenchy*, Case No. cv-09-201 (Me. Super. Ct.).

9. I am being compensated at an hourly rate for actual time devoted, at the rate of $275 per hour for any clinical services, review of records, or preparation of reports or declarations; $395 per hour for deposition and trial testimony; and $900 per day for travel time spent out of the office. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENDER IDENTITY AND GENDER DYSPHORIA

10. The term "gender identity" is a well-established concept in medicine, referring to one's sense of oneself as belonging to a particular gender. All human beings develop this elemental internal view: the conviction of belonging to a particular gender, such as male or female. Gender identity is firmly established early in life.

11. Typically, people born with anatomical features associated with females (vagina, uterus, ovaries) identify as girls or women, and experience themselves as female. Conversely, those persons born with typically male characteristics ordinarily identify as males. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned sex, giving rise to a sense of being "wrongly embodied."

12. The medical diagnosis for that feeling of incongruence and accompanying distress is gender dysphoria, which is codified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association) and the International Classification of Diseases-10 (World Health Organization). The condition is manifested by symptoms such as

preoccupation with ridding oneself of the primary and/or secondary sex characteristics associated with one's birth-assigned sex. Untreated gender dysphoria can result in significant clinical distress, debilitating depression, and often, suicidality.

13. The criteria for establishing a diagnosis of gender dysphoria in adolescents and adults are set forth in the DSM-V (302.85):

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

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated sex characteristics).

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

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

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

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

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

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

14. WPATH has established internationally accepted Standards of Care ("SOC") for the treatment of people with gender dysphoria. The SOC have been endorsed as the authoritative standards of care by leading medical and mental health organizations, including the American

Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association.

15. In accordance with the SOC, transgender individuals undergo medically-recommended transition in order to live in alignment with their gender identity.

16. The SOC identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (also referred to as social role transition).
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize or masculinize the body.
- Surgery to alter primary and/or secondary sex characteristics.

17. Like protocols for the treatment of other medical conditions, once a diagnosis is established, a treatment plan is developed based on an individualized assessment of the medical needs of the patient. Some combination of social role transition, hormone therapy, psychotherapy, and surgery is used to help the individual patient with gender dysphoria live congruently with his or her gender and eliminate the clinically significant distress caused by the condition.

18. Changes in gender presentation and role to masculinize or feminize appearance—social role transition—are an important component of treatment. This requires dressing, grooming, and otherwise outwardly presenting oneself consistently through social signifiers that correspond to one's gender identity in every aspect of life—at home, work, school, and in the broader community. This is an appropriate prerequisite of identity consolidation.

19. Although children who are transgender feel "different" and may be confused about the suitability of their assigned sex, they often abide anxiety until they are older, and learn

that there is a name for their experience—"transgender"—and a diagnosis—gender dysphoria. For some, this happens in adolescence, or even adulthood. Then, a sequential internal and external process ensues: accepting and identifying as transgender, explaining to family and others about the necessity of transition, disidentifying with the assigned gender and seeking support for post-transition life. The final stage—identity consolidation—is attained when the transgender aspect of life becomes less important, and the individual refocuses on the normal challenges of life like making a living, forming relationships, etc. With identity consolidation, the shame of having lived as a "false self" and the grief of being born into the "wrong body" can be ameliorated. If any aspect of this social transition is impeded however, it destabilizes the patient and undermines the treatment goals.

20. As noted, in addition to social transition, many transgender individuals undergo medical transition including hormone therapy and surgery.

21. Even without surgery, hormone therapy has a profound effect on the physical appearance of an individual. In boys and men who are transgender (*i.e.*, those assigned female at birth), for example, hormone therapy has a profound virilizing effect on appearance. The voice deepens, there is growth of facial and body hair, body fat is redistributed, and muscle mass increases. For girls and women who are transgender (*i.e.*, those assigned male at birth), hormone therapy has a profound feminizing effect on appearance. Fat is redistributed to the hips and the breasts, skin is softened, and there is a loss of muscle mass, a reduction of body hair, cessation of male-pattern hair loss, and atrophy of the penis, prostate and testes.

22. Many transgender individuals never undergo surgery. For many transgender individuals, surgery is not medically necessary as dysphoria is alleviated through social role transition and hormone therapy. For others, surgery is cost prohibitive because it is excluded

from coverage under many insurance plans. Additionally, there are several medical contraindications that preclude surgical treatment. These include: severe decompensating cardiovascular disease, brittle diabetes, history of multiple pulmonary emboli, history of stroke, history of anesthetic hyperthermia, brain aneurism, ongoing chemotherapy, morbid obesity, hepato-cellular disease, severe renal insufficiency, severe pulmonary disease, severe hemoglobinopathy, and uncontrolled endocrinopathy.

23. The goal of all treatment is to eliminate the distress caused by gender dysphoria. Treatment does not make a patient more or less of a man or a woman but instead brings an individual patient's body and presentation in line with who they already are at their core.

HARMFUL EFFECTS OF EXCLUSION FROM GENDER-APPROPRIATE FACILITIES

24. Social transition remains a critical part of treatment for transgender individuals and it is important that the social transition occur in all aspects of the individual's life. For a gender dysphoric young person or adult to be considered male in one situation, for example, but not in another is inconsistent with evidence-based medical practice and detrimental to the health and well-being of the individual, regardless of age. The integration of a consolidated identity into the daily activities of life is the aim of treatment. Thus, it is critical that the social transition be complete and unqualified—including with respect to the use of restrooms and other spaces and activities separated by sex.

25. Access to the same restrooms and other facilities available to others is an undeniable necessity for transgender individuals. Restrooms and locker rooms, unlike other settings (*e.g.*, the library or kitchen), categorize people according to gender. When it comes to sex-specific public restrooms and locker rooms, there are generally two, and only two, such categories designated: male and female. To deny a transgender individual access to such a

facility consistent with that person's gender identity, or to insist that a transgender individual use a separate restroom, communicates that such a person is not a "real" man or women; or that the person is some undifferentiated "other." Such segregation and identification of the individual as "other" interferes with the person's ability to consolidate identity and undermines the social-transition process.

26. Denial of restroom use in accordance with appearance and gender identity causes the use of such facilities to become a source of anxiety. Such anticipatory anxiety makes it difficult to concentrate at school or in the workplace. Transgender people go to great lengths to transition from their assigned birth gender. Expelling these individuals from spaces with peers can be deeply traumatic (particularly for adolescents), and exacerbates the depression, anxiety and isolation that many transgender people experience. Indeed, research shows that transgender individuals are at far greater risk for severe health consequences, and 41% have attempted suicide, a rate much higher than the baseline in North America.

27. Sending the message that a person is different from peers, and needs to be segregated, triggers shame. External attempts to negate a person's gender identity constitute identity threat. Developing and integrating a positive sense of self-identity formation is a developmental task for all human beings. For the transgender individual, the process is more complex, as the "self" violates society's norms and expectations. Attempts to negate a person's identity—such as excluding transgender people from gendered restrooms—challenges the legitimacy of identity, erodes resilience and poses health risks, including depression, posttraumatic stress disorder, hypertension and self-harm. In a study of transgender youth age 15 to 21, investigators found school to be the most traumatic aspect of growing up. Experiences of rejection and discrimination from teachers and school personnel led to feelings of shame and

unworthiness. The stigmatization to which they were routinely subjected led many to experience academic difficulties and to drop out of school.

28. For the majority of transgender people, social role transition allows for the social and legal recognition of their gender thereby conferring privacy—the right to maintain stewardship of personal and medical information—and allowing the individual to live safely and comfortably. Forcing a transgender individual into spaces designated for their birth-assigned sex and inconsistent with their gender identity can also lead to harassment and violence against the transgender individual.

29. A 2012 research study of discrimination and implications for health concluded: "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses."

30. Until recently, it was not fully understood that these experiences of shame and discrimination could have serious and enduring consequences. But it is now known that stigmatization and victimization are some of the most powerful predictors of current and future mental health problems, including the development of psychiatric disorders. The social problems that transgender teens face at school actually create the blueprint for future mental health, life satisfaction, and even physical health. A recent study of 245 gender-nonconforming adults found that stress and victimization at school was associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and suicidality in adulthood.

31. A wealth of research establishes that transgender people suffer from stigma and shame. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. The stress process can be both external, *i.e.*, actual experiences of rejection and discrimination (enacted stigma), and as a result of such experiences,

internal, *i.e.*, perceived rejection and the expectation of being rejected or discriminated against (felt stigma). A 2012 study of transgender adults found fear of discrimination increased risk of developing hypertension by 100%, owing to the intersectionality of shame and cardiovascular reactivity. A 2011 Institute of Medicine (IOM) report concurs: "the marginalization of transgender people from society is having a devastating effect on their physical and mental health." The American Journal of Public Health recently reported that more than half of transgender women "struggle with depression from the stigma, shame and isolation caused by how others treat them."

32. Privacy is essential in order to accomplish the therapeutic aims of treatment for gender dysphoria. Use of facilities that correspond to one's lived experience and appearance is integral to social recognition of identity.

33. Privacy surrounding one's gender dysphoria enables normal psychological functioning, the ability to have experiences that promote healthy personal growth and interpersonal relationships, and allows for control over the circumstances in which a person may disclose being transgender. It is the basis for the development of individuality and autonomy for transgender people.

34. Requiring transgender individuals to use facilities that do not match their gender identity may violate their privacy and release confidential medical information to others. The repetition of such negative experiences erodes resilience and coping mechanisms. The harms caused by House Bill 2 are predictable and dire, exacerbating symptoms of gender dysphoria and undermining clearly established treatment protocols in an already vulnerable population.

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

Executed on 5 · 12, 2016.

By: Randi Ettner PhD.
Randi Ettner, Ph.D.