UNITED STATES DISTRICT COURT
DISTRICT OF PUERTO RICO

DANIELA ARROYO GONZÁLEZ; VICTORIA RODRÍGUEZ-ROLDÁN; J.G.; and PUERTO RICO PARA TOD@S,

Plaintiffs,

v.

RICARDO ROSSELLÓ-NEVARES, in his official capacity as Governor of the Commonwealth of Puerto Rico; RAFAEL RODRÍGUEZ-MERCADO, in his official capacity as Secretary of the Department of Health of the Commonwealth of Puerto Rico; and WANDA LLOVET-DÍAZ, in her official capacity as Director of the Division of Demographic Registry and Vital Statistics of the Commonwealth of Puerto Rico,

Defendants.

Civil No. 3:17-cv-01457-CCC

DECLARATION OF DR. RANDI C. ETTNER, Ph.D.

I, Dr. Randi C. Ettner, declare as follows:

1. I submit this expert declaration based on my personal knowledge.

2. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

Qualifications and Basis of Opinion

3. I am a licensed clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I received my doctorate in psychology from Northwestern University in 1979. I have been the chief psychologist at the Chicago Gender Center since 2005, which specializes in the treatment of individuals with gender dysphoria. I have been involved in the treatment of patients with gender dysphoria since 1977, when I was an intern at Cook County Hospital in Chicago.

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

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

6. I am the Secretary and member of the Executive Board of Directors of the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin Gender Dysphoria Association) and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People*, 7th version, published in 2012. The WPATH promulgated Standards of Care ("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. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on gender dysphoria at medical hospitals. I am an honoree of the *Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota*, and have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities.

8. I have been retained as an expert regarding gender dysphoria and its treatment in multiple federal court proceedings, and have repeatedly qualified as an expert.

9. My clinical consulting fee in this case is $300 USD per hour.

10. In preparing this declaration, I have relied on my extensive professional experience and my review of the medical literature, including my own, related to gender dysphoria over the past three decades.

11. A true and accurate copy of my Curriculum Vitae is attached hereto as Exhibit A, which documents my education, training, research, and years of experience in this field. A bibliography of the materials reviewed in connection with this declaration is attached hereto as Exhibit B. The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

12. I have not met or spoken with the Plaintiffs for purposes of this declaration. My opinions are based solely on the information I have been provided by Plaintiffs' attorneys as well as my extensive experience studying gender dysphoria and in treating transgender patients.

Sex and Gender Identity

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

14. External genitalia alone—the critical criterion for assigning sex at birth—is not an accurate proxy for a person's sex.

15. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectible through karyotyping); gonads and internal reproductive organs (detectible by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); sexual differentiations in brain development and structure (detectible by functional magnetic resonance imaging studies and autopsy); and gender identity.

16. Gender identity is a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity. It is detectible by self-disclosure in adolescents and adults. In children under age 4, it is detectable by behaviors that are persistent and discordant with the sex assigned at birth (meaning the sex recorded on a person's birth certificate at the time of birth).

17. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation. Developmentally, it is the overarching determinant of the self-system, influencing personality, a sense of mastery, relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of satisfaction and quality of life. Psychologist Eric Erickson defined identity as "the single motivating force in life."

18. Like non-transgender people (also known as cisgender people), transgender people do not simply have a "preference" to act or behave consistently with their gender identities. Every person has a gender identity. It is a firmly established elemental component of the self-system of every human being.

19. The only difference between transgender people and cisgender people is that the latter have gender identities that are consistent with their birth-assigned sex whereas the former

do not. A transgender man cannot simply turn off his gender identity like a switch, any more than anyone else could.

20. In other words, transgender men are men and transgender women are women.

21. A growing assemblage of research documents that gender identity is immutable and biologically based. Efforts to change an individual's gender identity are therefore both futile and unethical.

22. For example, with the advent of sophisticated brain imagery techniques, researchers are now able to study large numbers of brains in living people, rather than via autopsy. These studies show that the cortex of the brain is the seat of the most consistently documented differences between transgender and non-transgender people. Brain bundles that connect the regions of the brain, white and gray matter, and intracranial volume are implicated before and immediately after birth (perinatally) in the architecture of the cortex. Differences in intracranial volume, cortical thickness, the putamen, and other areas in the right hemisphere of the brain, are sexually dimorphic. These neurodevelopmental differences in the brain cannot be changed.

23. Additionally, as early as 2000, researchers found that the probability of a sibling of a transgender person also being transgender was almost five times higher than the general public, and that twins have a 33.3% concordance rate for transgenderism, even when raised apart. This also suggests a genetic component, and some researchers are looking at specific genes that may help explain the origins of gender incongruity.

24. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, further underscores the innate and immutable nature of gender identity. Past attempts to "cure" transgender individuals by means of

psychotherapy, aversion treatments or electroshock therapy, in order to change their gender identity to match their birth-assigned sex, have proven ineffective and caused extreme psychological damage. All major associations of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, the American Psychological Association, and WPATH's Standards of Care, consider such efforts unethical.

Gender Dysphoria and Its Treatment

25. Gender Dysphoria is the clinically significant distress or impairment of functioning that can result from the incongruence between a person's gender identity and the sex assigned to them at birth. Gender dysphoria is a serious medical condition associated with severe and unremitting emotional pain from the incongruity between various aspects of one's sex. It is codified in the *International Classification of Diseases* (10th revision: World Health Organization), the diagnostic and coding compendia for mental health and medical professionals, and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM-5). People diagnosed with gender dysphoria have an intense and persistent discomfort with their assigned sex.

26. Gender dysphoria was previously referred to as gender identity disorder. In 2013, the American Psychiatric Association changed the name and diagnostic criteria to be "more descriptive than the previous DSM-IV term gender identity disorder and focus[] on dysphoria as the clinical problem, not identity per se." DSM-5 at 451.

27. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six 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 secondary sex characteristics).

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

28. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated. Without treatment, individuals with gender dysphoria experience anxiety,

depression, suicidality and other attendant mental health issues and are often unable to adequately function in occupational, social, or other areas of life.

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

30. The *American Medical Association*, the *Endocrine Society*, the *American Psychological Association*, the *American Psychiatric Association*, the *World Health Organization*, the *American Academy of Family Physicians*, the *National Commission of Correctional Health Care,* the *American Public Health Association*, the *National Association of Social Workers,* the *American College of Obstetrics and Gynecology*, the *American Society of Plastic Surgeons*, and *The American Society of Gender Surgeons* all endorse protocols in accordance with the WPATH standards. (*See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).)

31. The Standards of Care identify the following treatment protocols for treating individuals with gender dysphoria, which should be tailored to the patient's individual medical needs:

- Changes in gender expression and role, also known as social transition (which involves living in the gender role consistent with one's gender identity);

- Hormone therapy to feminize or masculinize the body in order to reduce the distress caused by the discordance between one's gender identity and sex assigned at birth;
- Surgery to change primary and/or secondary sex characteristics; and
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; and promoting resilience.

32. These treatments do not change a transgender person's sex, which is already determined by their gender identity. Attempts to change a person's gender identity to bring it into alignment with their birth-assigned sex are not only futile, but also dangerous and unethical.

The Process of Gender Transition

33. Gender transition is the process through which a person begins bringing their outer appearance and lived experience into alignment with their core gender. Transition may or may not include medical or legal aspects such as taking hormones, having surgeries, or correcting the sex designation on identity documents. Social transition—which often includes correcting one's identity documents to accurately reflect one's sex—is the most important, and sometimes the only, aspect of transition that transgender people undertake. Changes often associated with a social transition include changes in clothing, name, pronouns, and hairstyle.

34. A complete transition is one in which a person attains a sense of lasting personal comfort with their gendered self, thus maximizing overall health, well-being, and personal safety. Social role transition has an enormous impact in the treatment of gender dysphoria. An

early seminal study emphasizes the importance of aligning presentation and identity. Greenberg and Laurence (1981) compared the psychiatric status of individuals with gender dysphoria who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were living in their birth-assigned sex.

35. Hormones are often medically indicated for patients with gender dysphoria, and are extremely therapeutic. In addition to inducing a sense of wellbeing, owing to the influence of sex steroids on the brain, hormones induce physical changes which attenuate the dysphoria. One or more surgical procedures are medically indicated for some, but by no means all, transgender individuals.

36. A person's gender identity is an innate, immutable characteristic; it is not determined by a particular medical treatment or procedure. The medical treatments provided to transgender people (including social transition), do not "change a woman into a man" or vice versa. Instead, they affirm the authentic gender that an individual person *is*.

37. The goal of proper treatment is to align the person's body and lived experience with the person's fixed identity as male or female, which already exists. Treatment creates more alignment between the person's identity and the person's appearance, attenuating the dysphoria, and allowing the person's actual sex to be seen and recognized by others. Treatments fall below the accepted Standards of Care if they fail to recognize that a person's affirmed gender identity is not how they feel, but rather essentially who they are.

The Importance of Accurate Identity Documents, Including Birth Certificates, for Transgender People

38. Being unable to correct the gender marker on one's identity documents, including one's birth certificate, means that transgender people are forced to display documents that

indicate their birth-assigned sex (typically assumed based only by the appearance of genitalia at birth), rather than their actual sex as determined by their gender identity and their lived experience. This discordance creates a myriad of deleterious social and psychological consequences.

39. Identity documents consistent with one's lived experience affirm and consolidate one's gender identity, mitigating distress and functional consequences. Changes in gender presentation and role, to feminize or masculinize appearance, and social and legal recognition, are crucial components of treatment for gender dysphoria. Social transition involves dressing, grooming, and otherwise outwardly presenting oneself through social signifiers of a person's true sex as determined by their affirmed gender identity.

40. Through this process, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" are ameliorated. Being socially and legally recognized with correct identification is essential to successful treatment. The WPATH Standards of Care explicitly state that changing the gender marker on identity documents greatly assists in alleviating gender dysphoria. Uncorrected identity documents serve as constant reminders that one's identity is perceived by society and government as "illegitimate." Individuals who desire and require surgery must, as a prerequisite, undergo social role transition, which can be thwarted or upended by inaccurate identification documents.

41. An inability to access identity documents that accurately reflect one's true sex is harmful and exacerbates gender dysphoria, kindling shame and amplifying fear of exposure. Inaccurate documents can cause an individual to isolate, in order to avoid situations that might evoke discrimination, ridicule, accusations of fraud, harassment, or even violence—experiences that are all too common among transgender people. Ultimately, this leads to feelings of

hopelessness, lack of agency, and despair. Being stripped of one's dignity, privacy, and the ability to move freely in society can lead to a degradation of coping strategies and cause major psychiatric disorders, including generalized anxiety disorder, major depressive disorder, posttraumatic stress disorder, emotional decompensation, and suicidality. Research has demonstrated that transgender women who fear disclosure are at 100% increased risk for hypertension, owing to the intersection of stress and cardiac reactivity.

42. An abundance of research establishes that transgender people suffer from stigma and discrimination. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. This stress can be both *external*, i.e., actual experiences of rejection or discrimination (enacted stigma), and, as a result of such experiences, *internal*, i.e., perceived rejection or the expectation of being humiliated or discriminated against (felt stigma). Both are corrosive to physical and mental health.

43. Until recently, it wasn't understood that these experiences of humiliation and discrimination have serious and enduring consequences. It is now well documented that stigmatization and victimization are the most powerful predictors of current and future mental health problems. The presentation of a birth certificate is required in numerous situations. For the transgender individual, an inaccurate birth certificate can transform a mundane interaction into a traumatic experience. Repeated negative experiences inevitably erode resilience, creating an ingravescent course of gender dysphoria and attendant psychiatric disorders.

44. Many people who suffer from gender dysphoria go to great lengths to align their physical characteristics, voice, mannerisms and appearance to match their gender identity. Since gender identity is immutable, these changes are the appropriate, and indeed the only treatment for the condition. Understandably, the desire to make an authentic appearance is of great concern

for transgender individuals, as the *sine qua non* of the gender dysphoria diagnosis is the desire to be regarded in accordance with one's true sex as determined by one's gender identity. Privacy, and the ability to control whether, when, how, and to whom to disclose one's transgender status, is essential to accomplishing this therapeutic aim.

45. Thus, when an individual implements a social role transition, legal recognition of that transition is vital and an accurate birth certificate is a crucial aspect of that recognition, in large part because congruent identity documentation confers privacy—the right to maintain stewardship of personal and medical information—allowing an individual to live a safe and healthy life.

Surgical or Hormonal Therapies Should Not be Required to Correct the Gender Marker On a Person's Identity Documents

46. From a medical and scientific perspective, there is no basis for refusing to acknowledge a transgender person's sex, as determined by their gender identity, based on whether that person has undergone surgery or any other medical treatment. The appearance of genitalia and/or the ratio of circulating sex steroids are not relevant to a person's innate and immutable gender identity.

47. Moreover, not all individuals with gender dysphoria require hormonal or surgical therapy. For some, social role transition may be the essential and sufficient therapeutic intervention to alleviate distress. Indeed, for many transgender individuals, surgery is not medically necessary or may be safely delayed for some time as their dysphoria is alleviated through social role transition and other medical treatments. It is estimated that only 33% of transgender individuals undergo some form of gender-related surgery. Not all individuals for whom surgical intervention is medically indicated are able to access these options due to financial and other systemic barriers to necessary medical treatments.

48. Many insurance companies have policies that specifically exclude coverage of hormonal and surgical treatments for gender dysphoria. Additionally, there are some medical complications that preclude surgical treatment. These include brittle diabetes, morbid obesity, recent history of stroke, or other uncontrolled disease or organ damage.

49. Thus, transgender people should not be required to undergo hormonal or surgical treatment in order to have identity documents (including birth certificates) that accurately reflect who they are.

Conclusion

50. Medical management of gender dysphoria includes the alignment of appearance, presentation, expression, and often, the body, to reflect a person's true sex as determined by their gender identity. Correcting the gender marker on identification documents confers social and legal recognition of identity and is crucial to this process. The necessity and importance of privacy is universal, and exists even in animals. A wide range of species avoid predators by managing information about internal states and future intentions, for purposes of survival. Privacy enables normal psychological functioning, the ability to have experiences that promote healthy personal growth and interpersonal relationships, and allows for measured self-disclosure. It is the basis for the development of individuality and autonomy.

51. For a transgender person, a birth certificate bearing an incorrect gender marker invades privacy, releases confidential medical information, and places the individual at risk for grave psychological and physical harm.

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

Dated: 6·23, 2017

Dr. Randi C. Ettner

Dr. Randi C. Ettner

Exhibit A

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

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Incarcerated Persons, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Chicago Gender Center
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff privileges attending psychologist; Advocate Lutheran General Hospital

EDUCATION

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

CLINICAL AND PROFESSIONAL EXPERIENCE

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

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

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

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

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

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

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents: WPATH global education initiative, Chicago, 2015; Atlanta, 2016; Ft. Lauderdale, 2016; Washington, D.C., 2016, Los Angeles, 2017, Minneapolis, 2017

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

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

Gender reassignment surgery- Midwestern Association of Plastic Surgeons, 2015

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

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

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

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

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

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013;

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin,* 1997.

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

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

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

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

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

PROFESSIONAL AFFILIATIONS

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

AWARDS AND HONORS

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

Phi Beta Kappa, 1971
Indiana University Women's Honor Society, 1969-1972
Indiana University Honors Program, 9-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972

Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

Exhibit B

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