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IN THE THIRTEENTH JUDICIAL DISTRICT COURT
COUNTY OF YELLOWSTONE

AMELIA VASQUEZ, an individual,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
STATE OF MONTANA; GREGORY GIANFORTE, in his official capacity as the Governor of the State of Montana; the MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; and ADAM MEIER, in his official capacity as the Director of the Montana Department of Public Health and Human Services,	)	**Case No.**
	)	**Judge**
Defendants.	)	

EXPERT 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. I have been retained by counsel for Plaintiffs as an expert in connection with the above-mentioned litigation. Specifically, I have been asked by Plaintiffs' counsel to provide my expert opinion regarding how Montana's law prohibiting transgender persons born in Montana from obtaining accurate birth certificates reflecting their sex and gender identity unless they obtain a court order "indicating that the sex of the person . . . has been changed by surgical procedure" affects transgender individuals.

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

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I. BACKGROUND AND QUALIFICATIONS

4. 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 was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to the Weiss Memorial Hospital. Since that time, I have been a consultant to the Center for Gender Confirmation Surgery at Weiss Memorial Hospital and a member of the Medical Staff. The center 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.

5. 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.

6. 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). 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 Transgender Health* and *Transgender Health*.

7. I am the immediate past Secretary of the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin Gender Dysphoria Association), and was a member of the Board of Directors for twelve years, and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People* (7th version), published in 2011. The WPATH-promulgated *Standards of Care* ("*Standards of*

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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.

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

9. I have been retained as an expert regarding gender dysphoria and its treatment in multiple court cases in both state and federal courts, as well as administrative proceedings, and have repeatedly qualified as an expert. I have also been a consultant to policy makers regarding appropriate care for transgender inmates and for the Centers for Medicare and Medicaid in the state of Illinois.

10. A true and accurate copy of my Curriculum Vitae is attached hereto as Exhibit A. It documents my education, training, research, and years of experience in this field and includes a list of publications. 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.

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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.

11. 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, the materials referenced in the Bibliography as Exhibit B and cited herein, and my extensive experience studying gender dysphoria and in treating transgender patients.

a. Previous Testimony

12. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D. Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328 (M.D. Tenn. 2020); *Eller v. Prince George's Cty. Public Sch.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Monroe v. Jeffreys*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho 2018); *Carrillo v U.S. Dep't of Justice Exec. Office of Immig. Rev.* (2017).

b. Compensation

13. I am being compensated for my work on this matter at a rate of $375.00 per hour for preparation of declarations and expert reports. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

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II. SUMMARY OF OPINIONS

14. 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 (Krebs & Davies, 1993). 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 (Altman, 1977; Margulis, 2003).

15. 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.

III. EXPERT OPINIONS

a. Sex and Gender Identity

16. 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.

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

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18. 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.

19. 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.

20. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex. Developmentally, identity 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" (1956).

21. 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 identity. Every person has a gender identity. It is a firmly established elemental component of the self-system of every human being.

22. 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.

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

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24. 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 (*see, e.g.*, Zhou, 1995; Bentz, et al, 2008; Diamond, 2013; Gomez-Gil, 2012; Uribe, et al, 2020).

25. 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, proved 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.

b. Gender Dysphoria and Its Treatment

26. 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 that leads to impairment in functioning.

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27. 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.

28. 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:

i. 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).

ii. 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).

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

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

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

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vi. 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.

29. 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.

30. Although rates of suicide are higher amongst the transgender community than the general population, a 2015 study identified several factors that were associated with large reductions in suicide risk. The study reported that having an identity document with a gender marker notation that matched their lived gender was associated with a large reduction in suicidal ideation and attempts. The study noted that having one or more of these concordant identity documents has the potential to prevent suicidal ideation and suicide attempts—demonstrating that in a hypothetical sampling of 1,000 transgender people who were permitted to change an identity document gender marker, 90 cases of ideation could be prevented, and, in a hypothetical sampling of 1,000 transgender people with suicidal ideation who were permitted to change an identity document gender marker, 230 suicide attempts could be prevented (Bauer, Scheim & Pyne). A review of 24 studies similarly found that social and legal gender validation was positively related to improved health outcomes (King & Gamarel, 2021).

31. 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.

32. 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).)

33. 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

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dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; and promoting resilience.

34. 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.

35. As I understand it, a new Montana law (SB280), requires that any transgender person who wishes to amend the sex designation on their birth certificate obtain a court order stating that their sex "has been changed by surgical procedure." From a medical standpoint, this mandate is impossible to fulfill, as surgery does not change a person's immutable sex.

c. The Process of Gender Transition

36. 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. Similarly, a recent study found that use of a transgender person's chosen name, if different from the one given at birth, was linked to reduced depression, suicidal ideation and suicidal behavior (Russell, Pollitt & Grossman, 2018).

37. Hormones are often medically indicated for patients with gender dysphoria, and are extremely therapeutic. In addition to inducing a sense of well-being, owing to the influence of sex steroids on the brain, hormones induce physical changes which attenuate the dysphoria. One or

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more surgical procedures are medically indicated for some, but by no means all, transgender individuals.

38. 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*.

39. The goal of proper treatment is to align the person's body and lived experience with the person's fixed identity 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.

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

40. 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 based only on 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.

41. 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,

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grooming, and otherwise outwardly presenting oneself through social signifiers of a person's true sex as determined by their affirmed gender identity.

42. 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 (Ettner, 1999; Bockting, 2014). 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.

43. 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 (Inness, 1992), 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 a 100% increased risk for hypertension, owing to the intersection of stress and cardiac reactivity (Ettner, Ettner & White, 2012).

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44. 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 (Bockting, 2014; Bradford, et al, 2013; Frost, Lehavot, & Meyer, 2015).

45. Until recently, it was not 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 (Ohasi, Anderson & Bolder, 2017; Hazenbuehler, et al, 2014).

46. 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.

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47. 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 (Barry, 2019; Restar et al, 2020).

48. 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, or based on the permanence of any particular transition-related 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.

49. 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.

50. 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, allergy to anesthesia, morbid obesity, recent history of stroke, or other uncontrolled disease or organ damage.

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51. 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.

IV. CONCLUSION

52. 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.

53. The necessity and importance of privacy is universal. 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.

54. For a transgender person, a birth certificate bearing an incorrect gender marker or revealing one's birth name risks disclosing the fact that the person is transgender. This disclosure invades privacy, releases confidential medical information, and places the individual at risk for grave psychological and physical harm. Drawing on the largest sample of transgender people ever surveyed—22,286 U.S. respondents—investigators found that those who had gender-concordant identity documents had far less psychological distress and less suicide attempts than individuals who were barred from correcting identity documents. The authors underscored the important role of government and administrative bodies in reducing distress by allowing access to documents that accurately reflect identity (Scheim, et al, 2020). Given the unequivocal health implications, The American Medical Association adopted a policy supporting removal of sex designation from

public birth certificates to shield people from discrimination and the invasion of privacy. According to a June 25, 2021 AMA press release: "Designating sex on birth certificates as male or female, and making that information available on the public portion, perpetuates a view that sex designation is permanent and fails to recognize the medical spectrum of gender identity. This . . . risks stifling an individual's self-expression and self-identification and contributes to marginalization and minoritization" (http://www.ama-assn.org/press-center/press-releases/ama-announced-policies-adopted-final-day-special-meeting).

Dated this 12 day of July, 2021.

Dr. Randi C. Ettner

Dr. Randi C. Ettner

State of Illinois

County of Cook

Signed and sworn (or affirmed) to before me on July 12, 2021

by Randi C. Ettner.

Christopher M. Romer

CHRISTOPHER M ROMER
Official Seal
-Notary Public - State of Illinois
My Commission Expires Oct 9, 2023