IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

ASHLEY DIAMOND,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. Action No. _____
	)	
BRIAN OWENS et al.,	)	
	)	
Defendants.	)	

DECLARATION OF DR. RANDI C. ETTNER

1. I, Dr. Randi C. Ettner, am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria.

2. I have been retained by counsel for Ashley Diamond ("Ms. Diamond") to provide the Court with scientific information about gender dysphoria and the standard of care for treatment, and to perform a clinical evaluation of Ashley Diamond. Except where noted, I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

Qualifications and Basis of Opinion

3. I received my doctorate in psychology from Northwestern University in 1979.

4. I am currently the chief psychologist at the Chicago Gender Center, but began working with individuals with gender dysphoria nearly forty years ago, as an intern at Cook County Hospital.

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

6. I have published three books concerning gender dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery* (Ettner, Monstrey, & Eyler; Routledge, 2007). I also have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population.

7. 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 for the Health of Transsexual, Transgender and Gender-Nonconforming People* (Seventh Version, 2012) (the "Standards of Care"). The 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.

8. 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*. I have also lectured throughout North America and Europe on topics related to gender dysphoria, and frequently give grand rounds presentations on gender dysphoria at medical hospitals.

9. I have been retained as an expert in multiple federal court proceedings involving the treatment of gender dysphoria in prison settings, and have been repeatedly qualified as an expert.

10. My clinical consulting fee is $250 per hour.

11. In preparing this declaration, I relied on a clinical interview of Ashley Diamond that I conducted on January 22, 2015, the results of psychodiagnostic exams, Ms. Diamond's mental health and medical records, my extensive professional experience, and the body of medical literature, including my own, concerning gender dysphoria.

12. A true and correct copy of my Curriculum Vitae is attached hereto as **Appendix A**. A bibliography of the resources I reviewed in connection with this declaration is attached hereto as **Appendix B**.

Background on the Diagnosis and Treatment of Gender Dysphoria

13. Gender dysphoria (previous nomenclature was gender identity disorder) is a serious medical condition that is codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition ("DSM-V"), and the World Health Organization's International Classification of Diseases, Tenth Edition.

14. Individuals with gender dysphoria, who are frequently referred to as "transsexual" or "transgender," experience incongruence between their gender identity and birth-assigned sex, along with clinically significant distress or impairment of functioning. The suffering that arises from gender dysphoria has often been described as "being trapped in the wrong body." "Dysphoria" is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition.

15. Gender dysphoria is considered severe when it interferes with areas of daily living or important areas of functioning, and is accompanied by clinically significant symptoms of emotional distress.

16. The diagnostic criteria for gender dysphoria in adolescents and adults are 1) clinically significant distress or impairment in social, occupational or other important areas of functioning 2) caused by 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:

- 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);
- 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);
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);
- 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).

17. Without treatment, individuals with gender dysphoria experience anxiety, depression, suicidality and other attendant mental health issues. (*See*, *e.g.*, Fraser, 2009; Schaefer & Wheeler, 2004; Ettner, 1999; Brown, 2000, DSM-V, 2013, Haas *et al.*, 2014).

18. Individuals without access to appropriate care, particularly those who are imprisoned, are often so desperate for relief that they resort to life-threatening attempts at auto-castration, the removal of one's testicles, in the hopes of eliminating the major source of testosterone that kindles the dysphoria. (Brown, 2010; Brown & McDuffie, 2009).

19. Gender dysphoria intensifies with age. Individuals commonly experience an intensification of symptoms at midlife. (Ettner & Wylie, 2013; Ettner, 2013).

20. The medically accepted standards for the treatment of gender dysphoria are set forth in the Standards of Care, first published in 1979. The Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world. The American Medical Association, the Endocrine Society, The American Psychological Association, The American Psychiatric

Association all support treatment in accordance with the WPATH standards. (*See* American Medical Association (2008) Resolution 122n (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) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments")).

21. Like protocols for the treatment of diabetes or other medical disorders, the Standards of Care apply to the treatment of gender dysphoria in incarcerated and non-incarcerated settings, and have been recognized by the National Commission on Correctional Health Care ("NCCHC") as the clinically accepted standards for the care of inmates with gender dysphoria. (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (October 18, 2009), http://www.ncchc.org/transgender-health-care-in-correctional-settings).

22. The Standards of Care establish that for many individuals with gender dysphoria, hormone therapy is effective, essential, and medically necessary treatment. (Standards of Care, Section VIII.)

23. Hormone therapy 1) significantly reduces the production of hormones associated with an individual's birth sex, thus altering secondary sex characteristics, and 2) replaces those circulating sex hormones with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.*, males born with insufficient testosterone or females born with insufficient estrogen). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009)).

24. Hormone therapy is profoundly effective in that it has two therapeutic effects: first, with hormonal treatment, the patient acquires congruent sex characteristics, *i.e.* for

transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; second, hormones act directly on the brain, via receptors sites for sex steroids, which promotes a sense of well-being and attenuates the dysphoria and attendant psychiatric symptoms, including suicidality, anxiety, depression, and impulses to engage in auto-castration or other acts of self-harm. (*See*, *e.g.*, Cohen-Kettenis & Gooren, 1992).

25. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and well documented in the literature. For example, in one study, researchers compared 187 transsexual patients who had received hormone therapy to others who had not. Untreated patients showed much higher levels of depression, anxiety, and social distress. (Rametti, *et al*., 2011; *see also* Colizzi, *et al*. 2014; Gorin- Lazard *et al*., 2011).

26. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association also all agree that hormone therapy is medically necessary treatment for many individuals with gender dysphoria. (*See* 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)).

27. The therapeutic physical and psychological effects of hormone therapy are so profound that individuals with gender dysphoria who lack access to medically supervised hormones often resort to procuring and using hormones without medical supervision. (Gooren, 2011). Hormone therapy, when indicated, is medically necessary, evidence-based, appropriate treatment for gender dysphoria.

28. The WPATH Standards of Care also inform clinical guidance as to the importance of the social signifiers of gender expression in treatment. Clothing and grooming that affirms one's gender, and the use of pronouns consistent with an individual's gender identity, are an important component of treatment protocols. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007).

29. The WPATH Standards also recognize that while many individuals with gender dysphoria can experience profound relief with hormone therapy and changes in gender expression alone, for others, relief from gender dysphoria cannot be achieved absent sex reassignment surgery, or surgical interventions such as genital or chest reconstruction that change primary or secondary sex characteristics, the safety and efficacy of which are well documented in the medical literature. (Pfafflin & Junge, 1998; Smith *et al*., 2005; Jarolim *et al*., 2009, Standards of Care). Individuals with gender dysphoria are referred for surgery when they meet the eligibility and readiness criteria set forth in the Standards of Care. (Standards of Care, Section XI.)

30. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated. The Standards of Care specify the qualifications professionals must meet in order to provide care to gender dysphoric patients. In particular, the WPATH Standards of Care stipulate that a mental health professional must have "[k]nowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria," and obtain continuing education in the assessment and treatment of gender dysphoria. The Standards of Care establish that professionals who are new to the field should work under the supervision of mental health professionals with established expertise in this area. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care or place patients at

significant medical risk. (Standards of Care, Section VIII).

31. Psychotherapy can provide support with the many issues that arise in tandem with gender dysphoria. Counseling however, is not a substitute for medically indicated treatment. By analogy, in diabetes, counseling might provide psychoeducation about living with a chronic condition, but it does not replace the need for insulin.

32. Similarly, treatments aimed primarily at the symptoms of anxiety or depression—*e.g.* anxiolytics, selective serotonin reuptake inhibitors, or mood-stabilizing psychotropic medication—do not provide relief from gender dysphoria and are not a substitute for appropriate treatment.

33. Providing only counseling and psychotropic medication to a severely gender dysphoric patient is a gross departure from medically accepted practice. Inadequate treatment of this disorder puts an individual at serious risk of psychological and physical harm (WPATH Medical Necessity Statement, 2010).

Clinical Observations & Assessment

34. On January 22, 2015, I conducted a three hour clinical assessment of Ashley Diamond at the Baldwin State Prison in Milledgeville, Georgia. My assessment consisted of a clinical interview and the administration of four standardized psychodiagnostic tests with high levels of validity and reliability: the Beck Depression Inventory-II, the Beck Anxiety Inventory, the Beck Hopelessness Scale, and the Traumatic Symptom Inventory. At 5 feet 10 inches and 135 pounds, Ms. Diamond appeared thin, with a BMI of 19.4. Her mood was anxious, and occasionally she wept when discussing her frustration at being denied treatment for gender dysphoria, and her constant fear for her safety.

35. As part of this clinical assessment, I conducted a complete sex and gender history of Ms. Diamond and obtained family, demographics, physical, education, and social information.

Relevant Background & History

36. Ms. Diamond grew up in the small town of Rome, Georgia, where she was the second of four children, and had several step-siblings.

37. From a young age, Ms. Diamond was very aware that she was unlike other boys. She would frequently dress in her mother's clothing, and admire how "pretty" she looked. Her parents, like most adults of that era, taught and enforced gender roles through shame. Ms. Diamond's mother, who was in the military, frequently subjected Ms. Diamond to "boy lessons,"— rebuking and punishing her for any display of female mannerisms or behavior. Ms. Diamond's father also insisted she play football, even though she was interested in singing, not sports.

38. At age 5, Ms. Diamond saw a cartoon character named "Jem" who, when she touched her earrings, was magically transformed into a rockstar who could disguise herself and avoid danger. This was immensely satisfying to young Ms. Diamond, who identified with Jem, and believed the magic might also be available to her. Once, she attended kindergarten "dressed up" as Jem, but was mercilessly teased and labeled as gay by her classmates. Ms. Diamond's parents were summoned to retrieve her from school.

39. Ms. Diamond's pre-adolescent and adolescent years were tumultuous; because she was "different," Ms. Diamond was subjected to a constant torrent of humiliation of abuse. The gnawing, relentless conviction that she was meant to be a girl was as perplexing to young Ms. Diamond as it was to everyone around her. But she knew this conviction to be intractable, while others thought it an affectation that could be shamed or beaten out of her.

40. Puberty galvanized Ms. Diamond's depression about being male. Ms. Diamond hated her genitals, and wore several pairs of underwear to conceal them.

41. With no hope of understanding or support from family, at 15, Ms. Diamond attempted suicide and was admitted to a psychiatric hospital. When Ms. Diamond expressed to a physician that "I hate living like this — I feel like a girl," he educated her about gender dysphoria — the condition from which she suffers.

42. From that moment on, Ms. Diamond realized that despite what she had heard all her life, she was not gay, nor was she a cross-dresser. She learned that individuals with body aversion and gender dysphoria are referred to as transgender. Ms. Diamond also learned that treatment for gender dysphoria consisted of hormones, female gender expression, and possibly surgery. Emboldened by this knowledge, Ms. Diamond told her family that she was never going to dress as a boy again. Her father could not abide her decision to live as a girl, and so Ms. Diamond left home and lived with a friend's family.

43. Ms. Diamond began taking feminizing hormones, and took them continuously for the seventeen years prior to her incarceration. Estrogen attenuated the dysphoria, depression, suicidal ideation, and conferred a sense of emotional well-being.

44. After leaving high school, Ms. Diamond worked at a series of retail jobs, but inevitably, when her employers learned that she was transgender, Ms. Diamond would be terminated. At age 18, she moved to Atlanta, where she lived for many years, but continued to experience job discrimination, and occasionally struggled to make ends meet.

45. Ms. Diamond states that she has not received hormonal therapy or access to female accoutrements since she entered the custody of the Georgia Department of Corrections in March 2012, which a review of the records corroborates.

Clinical Assessment

46. Ashley Diamond has persistent, severe gender dysphoria. She meets, and exceeds, full criteria for the DSM-V diagnosis of Gender Dysphoria in Adolescents and Adults, 302.85. Historically, she had Gender Identity Disorder in Childhood, 302.6, which persisted. Ms. Diamond has the diagnostic feature often referred to as "primary" transsexualism. In these rare cases, the feeling of "being trapped in the wrong body" is so severe that the adolescent never even attempts to live in the birth-assigned gender.

47. A review of records indicates that a series of mental health professionals from the Georgia Department of Corrections have confirmed Ms. Diamond's gender dysphoria diagnosis — though at times, using the former nomenclature "gender identity disorder." A cursory physical examination of Ms. Diamond would have also made her gender dysphoria diagnosis and treatment history irrefutable to corrections personnel, given the changes that occur to the body habitus subsequent to hormonal reassignment. To wit, Ms. Diamond had significant breast development (or gynecomastia), greatly decreased testicular size with reduction in size of external genitalia (and prostate), fat on the hips and buttocks, diminished upper body mass in chest and extremities, and very limited facial and body hair—a markedly atypical male phenotype.

48. The medically indicated treatment for Ms. Diamond's disorder consists of hormone therapy and the ability to live consistent with her affirmed gender, *i.e.* as a female. Indeed, this prescribed course of treatment had been in effect for the past seventeen years, and renders Ms. Diamond eligible for surgery, in accordance with the WPATH Standards of Care. When hormonal therapy is initiated at such a young age (presumably Tanner stage 4), secondary sex characteristics are readily established.

49. Psychotherapy is not a necessary or appropriate treatment modality for Ms. Diamond. She requires medical treatment, *i.e.* cross-sex hormones.

50. Ms. Diamond meets the criteria for posttraumatic stress disorder ("PTSD")—a diagnosis which has been confirmed by healthcare professionals in the Georgia Department of Corrections. Ms. Diamond presents with a classic posttraumatic response set, indicative of chronic response to events in the past. Specifically, she exhibits symptomotology of intrusive and unwanted thoughts of traumatic experiences (B cluster in 309.81 DSM-V). These include nightmares, flashbacks, upsetting memories easily triggered by current events, and repetitive thoughts of unpleasant experiences that intrude into awareness. Often this leads to feeling out of control. When anxiety is similarly elevated, as it is in this case, it signals autonomic hyperarousal. There is an attempt to deal with these symptoms by pushing them out of the mind, or to avoid places and events that re-stimulate painful memories (subsumed under the C group of PTSD symptoms).

51. In addition to the other severe and chronic psychological sequelae of trauma, sexual assaults, which Ms. Diamond has experienced since her incarceration, result in irremediable impairment in sexual health, including loss of libido and impaired self-reference.

Current Status

52. The termination of treatment—specifically hormone therapy and gender expression—has rekindled the gender dysphoria that she had successfully managed for nearly two decades. The lack of treatment has caused Ms. Diamond to have suicidal ideation, and she has attempted suicide on at least three occasions. She has made four attempts at auto-castration (removal of the testicles) and has attempted auto-penectomy (removal of the penis).

53. Ms. Diamond's attempts at auto-castration and suicide are a priori evidence of severe untreated gender dysphoria, and are the inevitable and predictable consequences of denying the medically necessary treatment Ms. Diamond requires.

54. Results of psychodiagnostic testing confirm that Ms. Diamond meets the criteria for severe depression, evidencing symptomotology on several parameters, predominately affective and somatic, including sadness, loss of interest (anhedonia), suicidal ideation, loss of appetite, and agitation.

55. Ms. Diamond also experiences symptoms associated with generalized anxiety. The intensity of the symptoms is severe, and represents subjective and panic-related aspects of anxiety. These include feeling discomfort in the abdomen, heart pounding or racing, difficulty breathing, and fear “of the worst happening.” This cluster of symptoms describes autonomic and neurophysiological aspects of anxiety, not subject to voluntary control or cognitive reappraisal. This level of anxiety is consistent with untreated gender dysphoria, as well as a diagnosis of generalized anxiety disorder or panic disorder without agoraphobia.

56. Most clinically significant, Ms. Diamond scores high on scales measuring the extent of hopelessness. Hopelessness is a psychological construct that underlies a variety of mental health disorders. Hopeless individuals believe that their important goals cannot be attained and that their worst problems will never be solved. (Stotland, 1969.) The Beck Hopelessness Scale has utility as an indirect indicator of suicidal risk in individuals who have had prior suicide attempts and ideation. Hopelessness has been repeatedly found to be a better predictor of suicide than depression, and hopelessness scores of 9 or higher are predictive of eventual suicide. (Beck,1986.) A study of 1,969 outpatients who were administered the Beck Hopelessness Scale found that of those who ultimately committed suicide, 93.8% had scores of 9

or higher. Clinicians are therefore advised to monitor patients describing moderate to severe levels of hopelessness for suicide potential. (Simon & Gold, 2012.) Ms. Diamond scored a 15 on this instrument, indicating her risk for suicide is severe.

57. With appropriate medical treatment for gender dysphoria, all of the aforementioned psychological symptoms would be attenuated or eliminated.

58. Hormones regulate all bodily functions. The stimulus for hormone release is complex, originating in the hypothalamus and prompting the pituitary to act on the endocrine glands: the thyroid, parathyroid, pancreas, adrenals, and gonads. Those polypeptides then circulate in the blood stream, acting on organ systems such as the pancreas, to produce insulin, which in turn acts on a cellular level, mediating the response on target organs. The roles of the hormone insulin in diabetes, or cortisol in Addison's disease, are mundane examples of the intricate interplay of psychological and somatic disorders that rely on precisely titrated hormonal interventions.

59. Ms. Diamond experienced the physical sequelae of withdrawal of hormones, including vascular dilation and leg pain, swelling of the feet (necessitating a soft shoe profile), heart palpitations, muscle spasms, hot flashes, vomiting, weight loss, diarrhea, fatigue and hyperhidrosis.

60. Given Ms. Diamond's lifelong gender dysphoria, the longer that appropriate medical treatment is withheld, the greater the risk she will experience devastating negative outcomes.

Adequacy of the Present Treatment Protocol

61. The Standards of Care are disseminated worldwide for the purpose of issuing clinical guidance to health professionals who provide treatment. According to the Standards of Care, if and when an individual meets the criteria for gender dysphoria, a formal diagnosis is

established. Ashley Diamond meets, and exceeds, the diagnostic criteria for gender dysphoria. Once a diagnosis is established, medical treatment options are initiated. The Standards of Care state that individuals "should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services."

62. Ashley Diamond did not receive the care proscribed by the Standards of Care. She received a diagnosis, but no assessment or medically indicated treatment under the Standards of Care. She was placed at considerable physical risk when her hormone treatment was terminated. She remains at risk for psychological decompensation, self-harm, and suicide.

63. The records I reviewed clearly corroborate my clinical assessment. The psychotherapist who is treating Ms. Diamond concurs that she requires medical treatment *i.e.* hormonal therapy and female grooming accoutrements. This provider has likewise documented suicidal ideation and emotional dysregulation in this inmate. She is in imminent danger of decompensation. In the resource-poor environment of prison and with a lack of appropriate medical care, there is little hope that mental health deterioration or self-harm can be avoided.

64. I have reviewed the Georgia Department of Correction's policy regarding care of transgender inmates. The policy provides for maintenance of an inmate's status, or what is commonly referred to as a "freeze frame" policy regarding treatment of gender dysphoria.

65. The refusal to treat a medical condition because it wasn't treated or was improperly treated prior to incarceration, is anathema to ethical health care delivery. By analogy, if a patient is diagnosed with diabetes while incarcerated, is insulin withheld because it wasn't provided prior to incarceration?

66. In recognition of the hazards of the "freeze frame" approach, the Standards of Care advise:

> People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the SOC [Standards of Care]. A "freeze frame" approach is not considered appropriate care…. People with gender dysphoria who are deemed appropriate for hormone therapy (following the SOC) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by auto-castration, depressed mood, dysphoria, and/or suicidality.
>
> (Standards of Care, Section XIV.)

Clinical Recommendations

67. Ashley Diamond is at extremely high risk for decompensation, owing to the undesired regression of hormonally-induced physical effects, and a growing sense of desperation. She has made four attempts at auto-castration, and attempted auto-penectomy. She has made multiple suicide attempts and expresses the intention to end her life if she is forced to live as a male. This desperation is the result of the termination of medically indicated treatment.

68. Untreated gender dysphoria dramatically increases suicide risk: Two recent surveys cite a 41% and 43% rate of suicide attempts in this population, far above the baseline rates for North America. It is clinically imperative to be attentive to the presence of suicide risk. Several lines of research suggest that individuals like Ms. Diamond who attempt suicide on multiple occasions are far more likely to die by suicide than are single attempters. Untreated gender dysphoria dramatically increases suicide risk: Two recent surveys cite a 41% and 43% rate of suicide attempts in this population, far above the baseline rates for North America.

69. Ms. Diamond requires immediate initiation of feminizing hormone therapy to treat the dysphoria, concomitant depression and suicidal ideation. Hormone therapy is the medically necessary treatment for her gender dysphoria, and it is safe, evidence-based, and effective. A typical protocol consists of estrogen administered transdermally or by injection, and anti-androgenic compounds, *e.g.* sprironolactone 100 mg per day.

70. Integral to successful treatment of gender dysphoria is the ability to present as a female. Ms. Diamond should be allowed to wear clothing and have a hair style that reflects her gender identity. She should be referred to with congruent gender pronouns *i.e.* "she" and "her."

71. The treatment of Ms. Diamond's disorder with psychotherapy and/or psychotropic drugs is a gross departure from the evidence-based Standard of Care, and is medically negligent. It places her at risk for self-harm or suicide.

72. Medically appropriate treatment — *i.e.* hormones and female grooming accoutrements — do not heighten an inmate's risk of victimization. Throughout the country, even in maximum security facilities, female identified gender dysphoric inmates live and appear as women.

73. The Standards of Care state: "Housing…for transsexual, transgender, and gender-nonconforming people living in institutions should take into account their gender identity and role, physical status dignity and personal safety…Institutions where transsexual, transgender, and gender non-conforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents." (Standards of Care, Section XIV.)

74. Housing Ms. Diamond in accordance with the Standards of Care can help prevent exacerbation of her PTSD. Ms. Diamond should also be treated with a selective-serotonin re-uptake inhibitor (SSRI) medication to see if the symptoms associated with her PTSD improve.

75. There are no contraindications to the implementation of an appropriate treatment plan for this inmate. The consequences of continuing to deny treatment, however, are predictable and dire.

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

Dated: February 19, 2015

Respectfully submitted,

Dr. Randi C. Ettner

APPENDIX A

RANDI ETTNER, PHD

1214 Lake Street
Evanston, Illinois 60201
Tel 847-328-3433 Fax 847-328-5890
rettner@aol.com

POSITIONS HELD

Clinical Psychologist

Forensic Psychologist

Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialities

Fellow and Diplomate in Trauma/PTSD

President, New Health Foundation Worldwide

Board of Directors, World Professional Association of Transgender Health (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

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
Major: Clinical Psychology

BA, 1969-72 Indiana University (cum laude)
Bloomington, Indiana
Major: psychology, Minor: sociology

1972 Moray College of Education

Edinburgh, Scotland
International Education Program

1970 Harvard University
Cambridge, Massachusetts
Social relation undergraduate summer program in group dynamics and processes

CLINICAL AND PROFESSIONAL EXPERIENCE

Present 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

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

BOOKS & PUBLICATIONS

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PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School — Leadership Council

American College of Forensic Psychologists

World Professional Association for Transgender Health

Advisory Board, Literature for All of Us

American Psychological Association

American College of Forensic Examiners

Society for the Scientific Study of Sexuality

Screenwriters and Actors Guild

Board of Directors, Chiaravalle Montessori School

Phi Beta Kappa

AWARDS AND HONORS

Phi Beta Kappa, 1971

Indiana University Women's Honor Society, 1969-1972

Indiana University Honors Program, 1969-1972

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

APPENDIX B

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