UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JANE DOE, Plaintiff v. MASSACHUSETTS DEPARTMENT OF CORRECTION; THOMAS A. TURCO III; SEAN MEDEIROS; JAMES M. O'GARA JR.; and STEPHANIE COLLINS, Defendants.	Civil Action No. 17-12255-RGS

AFFIDAVIT OF RANDI ETTNER, PH.D.

1. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

2. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance from 1977 to present. 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 (co-editors Monstrey & Eyler; Rutledge 2007; and the 2d edition (co-editors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population. I have served as a member

of the University of Chicago Gender Board, and am on the editorial boards of The International Journal of Transgenderism and Transgender Health. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,000 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Incarcerated Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, Europe, and Asia on topics related to Gender Dysphoria and have given grand rounds on Gender Dysphoria at university 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. A copy of my *Curriculum Vitae* is attached as Exhibit A.

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

4. At birth, infants are classified as male or female. This classification becomes the person's birth-assigned gender. Typically, persons born with the physical characteristics of males psychologically identify as men, and those with the physical characteristics of females

psychologically identify as women. However, for transgender individuals, this is not the case. The body and the person's gender identity do not match. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned gender, giving rise to a sense of being "wrongly embodied."

5. For many transgender people, this incongruence between gender identity and assigned gender does not interfere with their lives. For others, however, the incongruence results in Gender Dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one's assigned gender.

6. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

7. In 2013, with the publication of DSM-5, the Gender Identity Disorder diagnosis was removed and replaced with Gender Dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's *identity* disordered. Rather, the diagnosis is based on the distress or *dysphoria* that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis connoted "that the patient is 'disordered'." American Psychiatric Association, Gender Dysphoria (2013), http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf. But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a

mental disorder. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition." *Id*. By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)

8. In addition, the categorization of Gender Dysphoria and its placement in the DSM system is different for Gender Dysphoria than it was for GID. In every version of DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own.

9. Importantly, neither the GID nor Gender Dysphoria are disorders of sexual behavior. Neither diagnosis has ever been classified in any DSM version as a disorder of sexual behavior, including as a Paraphilic Disorder.

10. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated 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.

11. In addition to renaming and reclassifying Gender Dysphoria, the medical research that supports the Gender Dysphoria diagnosis has evolved. Unlike DSM's treatment of GIDs, the DSM-5 includes a section entitled "Genetics and Physiology," which discuss the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygoticsame-sex twins, and some degree of heritability of gender dysphoria").

12. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology. It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.,* Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment. A Diffusion Tensor Imaging Study*, 45 J. Psychiatric Res. 199-204 (2010); Giuseppina Rametti et al., The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study, 45 J. Psychiatric Res. 949-54 (2011); Eileen Luders et al., *Gender effects on cortical thickness and the*

influence of scaling, 2 J. Behav. & Brain Sci. 357, 360 (2012); FPM Krujiver, et al., *Male-to-female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034-2041 (2000). Interestingly, differences in transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self.

13. In addition, scientific investigation has found a co-occurrence of gender dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. E. Gomez-Gil, et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265-269 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of gender dysphoria. *See* Milton Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int'l J. Transgenderism 24 (2013) (abstract: "[t]he responses of our twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing."). *See also* R Green, *Family co-occurrence of "gender dysphoria": ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499-507 (2000).

14. It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing

> neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Ai-Min Bao & Dick F. Swaab, *Sexual Differentiation of the Human Brain: Relation to Gender Identity, Sexual Orientation and Neuro-psychiatric Disorders*, 32 Frontiers in Neurology 214-216 (2011). In addition, Alicia Garcia-Falgueras & Dick F. Swaab find that:

> [t]he fetal brain develops during the intrauterine period in the male direction through a direct action of testosterone on the developing nerve cells, or in the female direction through the absence of this hormone surge. In this way, our gender identity (the conviction of belonging to the male or female gender) and sexual orientation are programmed or organized into our brain structures when we are still in the womb. However, since sexual differentiation of the genitals takes place in the first two months of a pregnancy and sexual differentiation of the brain starts in the second half of the pregnancy, these two processes can be influenced independently, which may result in extreme cases in transsexuality. This also means that in the event of ambiguous sex at birth, the degree of masculinization of the genitals may not reflect the degree of masculinization of the brain. There is no indication that social environment after birth has an effect on gender identity or sexual orientation.

Alicia Garcia-Falgueras & Dick F. Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 Pediatric Neuroendocrinology 22-25 (2010). Similarly, Lauren Hare et al. finds that:

> a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Lauren Hare, et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 Biological Psychiatry 93, 93, 96 (2009). Because the condition is biologically based, efforts to change a person's gender identity are futile, cause psychological harm, and are unethical.

15. Without treatment, adults with Gender Dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental

health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. Many people without access to appropriate care 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. A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

16. Gender Dysphoria can be ameliorated through medical treatment. The standards of care for treatment of Gender Dysphoria are set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (7th version, 2011). The WPATH promulgated Standards of Care (SOC) 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,* the *World Health Organization*, the *American Academy of Family Physicians*, the *American Public Health Association*, the *National Association of Social Workers,* the *American College of Obstetrics and Gynecology* and the *American Society of Plastic Surgeons* all endorse protocols in accordance with the WPATH SOC. *See, e.g.*, American Medical Association (2008) Resolution 122 n(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).

17. As part of the SOC, many transgender individuals with Gender Dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- 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; or promoting resilience.

18. The treatment of incarcerated persons with Gender Dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of Gender Dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the WPATH SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the WPATH SOC for people in correctional settings (NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), http: //www.ncchc.org/transgender-transsexual-and gender-nonconforming health-care).

19. A key component of medical treatment for gender dysphoric individuals is to live, function in society, and be regarded by others consistent with their gender identity. If any aspect

of this social role transition is impeded, it will undermine an individual's core identity and psychological health.

20. Housing and shower/bathroom facilities for individuals with Gender Dysphoria in institutional settings should be in accord with their gender identity and social role. The failure to treat a woman with Gender dysphoria as a woman in an institutional setting will intensify gender dysphoria and psychological distress and can precipitate psychiatric disorders.

21. I have reviewed Plaintiff Jane Doe's correctional medical records and conducted a psychological evaluation of her in person at MCI Norfolk on December 11, 2017. My evaluation consisted of an interview and the administration of a series of four standard psychometric indices.

22. Ms. Doe has long-standing, persistent, and well-documented early-onset Gender Dysphoria. There is no controversy about her diagnosis. She was gender dysphoric as a child and by age 13 her mother took her to a doctor for treatment of her gender incongruence. She has been on cross-gender hormone therapy since she was a teenager. Although Ms. Doe originally received a diagnosis of GID, consistent with the version of DSM in effect at that time, she meets all the criteria for and has a diagnosis of Gender Dysphoria.

23. Ms. Doe's Gender Dysphoria requires life-long medical care and monitoring in accordance with the treatment protocols in the SOC, including with respect to hormone therapy and the requirement that she live and function as a woman.

24. Based on the contemporary scientific and medical understanding of sex, Ms. Doe is female. The fact that she is transgender – that is, that she was ascribed the sex of male when born notwithstanding her female gender identity – does not alter that conclusion.

25. Based on current scientific and medical knowledge and understanding, sex is composed of several components: brain phenotype, gender identity, chromosomes and the hormones they script, internal reproductive organs and external genital structures.

26. For adults, where there is any lack of congruity among these characteristics, gender identity predominates in prioritizing these determinants. There is no dispute that Ms. Doe has a female gender identity.

27. After approximately four decades of appropriate, confirming hormones, Ms. Doe has been *hormonally reassigned*. In other words, she has the same circulating sex steroid hormones as perimenopausal females. Her testosterone levels are barely measurable and similarly in the reference range appropriate for a female.

28. Hormones have a primary effect on the brain, but also regulate every bodily system. Due to her long-term hormone therapy and estrogen levels comparable to other females, Ms. Doe has the secondary sex characteristics of a woman. She has normal female breast development. Consistent with her long-time hormone levels she also has softened skin, diminution of body hair, the absence of male pattern baldness, redistribution of body fat consistent with a female shaped body, loss of muscle mass, and genital changes.

29. Unlike people who transition later in life, Ms. Doe never attempted to live in her assigned birth gender. Individuals who begin cross-sex hormone therapy in adolescence never develop the male secondary sex characteristics, which aids enormously in the attainment of an authentic female presentation. Ms. Doe attended school as a girl and was treated as a girl by family, friends, and the community at large. She was never socialized as a *male.*

30. Based on her female hormone levels and the absence of testosterone, Ms. Doe's genitals would not appear or function as normal male genitals. Female hormone therapy,

especially when started at such an early age, creates considerable changes to genitalia. If one were to view her naked, as corrections officers strip-searching her do, her genitals would not visibly appear the same as male inmates. There would be significant atrophy and decreased mass of the penis and testicles due to the lack of testosterone. In addition, the hormonal changes would render her unable to have erections, produce ejaculate fluid, or engage in penetrative sex. Functionally, Ms. Doe's genitals are used only to urinate.

31. Due to treatment for Gender Dysphoria, Ms. Doe is not capable of reproduction.

32. My assessment of Ms. Doe's current psychological condition is based on my review of her records, my interview of her, and the administration of four standardized psychometric indices with high levels of reliability and validity: The Beck Anxiety Inventory, The Beck Depression Inventory-II, the Traumatic Symptom Inventory-2, and the Beck Hopelessness Scale.

33. Based on my assessment, it is my opinion that Ms. Doe has developed Posttraumatic Stress Disorder and a Generalized Anxiety Disorder as a direct result of being housed in a prison with male inmates and the intentional intimidation, harassment, and sexual objectification she has regularly experienced in that setting. She has no history of trauma or psychiatric disorders prior to her incarceration. The diagnosis of posttraumatic stress disorder is based on her current and acute symptoms and behaviors and the traumatic stressors she is routinely subjected to in her present environment. She has clinically elevated indicia of trauma, and scored in the severe range on a test of anxiety associated with hyperarousal and fear that are beyond her cognitive control. She has intrusive experiences such as nightmares and flashbacks and lives in constant fear of what will happen to her next.

34. Ms. Doe now suffers from "complex trauma." Complex trauma is a result of traumatic stressors that are interpersonal, i.e. *intentionally* caused and planned by humans. This

interpersonal trauma usually occurs when there is a power differential between the victim and the aggressor, and is more harmful and intractable than random or impersonal trauma, i.e. "acts of God." Additionally, interpersonal victimization is typically repeated and chronic. Whether it occurs routinely or intermittently, the victim does not have adequate time to regain emotional equilibrium between "assaults" and the fear that another attack can occur at any moment leads to states of hypervigilance, autonomic hyperarousal, hyperalertness and anxiety or panic attacks. This causes actual neurological damage - a dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the neurocircuitry of the brain. People with posttraumatic stress disorder can no longer mediate the fight-flight-freeze response.

35. Being referred to by the appropriate female name and being respectfully treated as a woman are crucial to the psychological well-being of a gender dysphoric woman. Absent respectful and appropriate interactions, psychological symptoms and disorders develop. Although deeply disturbing, the psychological harm from the placement of a woman in a male prison is not surprising, given what Ms. Doe has experienced at MCI-Norfolk. It is extremely distressing for a transgender woman to be viewed naked by male inmates; strip-searched by male guards who touch and grope her; forced to shower in view of male prisoners who crowd in excitedly to view her as a sex object; told by guards that she is a man because she has a penis; be referred to as a "chick with a dick," and "a wannabe woman"; and to be called "Mr. Doe" and referred to with male pronouns. When I asked Ms. Doe what was the worst thing that happened to her at this facility, she cried, and related a particularly disturbing incident in which a corrections officer intentionally made her shower on the second floor in the 3-2 Unit in front of male inmates. Not only was she feeling ashamed, but she also was fearful of being raped, as the male inmates talked about what she could do with her lips. Each of these humiliating incidents is

devastating and threatens her emotional stability because they do not emanate from mistakes or inadvertence. They are obvious and intentional attempts to harass, insult, stigmatize and undermine her female identity. These conditions would be damaging to any transgender woman, but they are especially traumatic for Ms. Doe, because having transitioned as a youngster, she has always only been treated as female. For her, the impact of not being treated as a woman is particularly demoralizing.

36. Strip searches by male correctional officers have a devastating impact on Ms. Doe. She has a female body with female breasts. That the same men who have been harassing her can put their hands on her is extremely traumatic.

37. Based on my assessment, it is my opinion that Ms. Doe's mental health is steadily devolving. If she remains in a male prison under the current conditions, she is at risk for further emotional and physical decline. Her coping strategies have diminished, and her resilience is rapidly eroding. In the face of intense stressors, and with no personal agency, symptoms intensify rendering an individual incapable of functioning, a condition known as psychological decompensation, which can be irremediable.

38. Excessive stress induces high levels of cortisol. This surge of cortisol leads to neural excitability and sometimes psychoses. Excessive cortisol may also accelerate the metabolism of Ms. Doe's hormones, which would render them less effective.

39. All of Ms. Doe's symptoms will improve if she is placed in a women's prison. While some anxiety symptoms may now be intractable, they will be attenuated. She will likely be largely symptom-free if placed in an appropriate facility and treated as a female.

40. Ms. Doe will function well in a women's prison. She has lived as a female her whole life, excluding periods of incarceration.

41. There is no danger that Ms. Doe would be physically or sexually assaultive to other women. Her test results show markedly low levels of anger and aggression. She is a pleasant person with no personality disorders, sociopathic tendencies, or any other maladaptive personality traits that could create a troublesome situation in any correctional setting. Her personality profile is passive. She does not fight back, but is more prone to, in lay person's terms, take anger and frustration out on herself.

42. Ms. Doe has no sexual disturbances or dysfunctional sexual behavior. She has no problem with sexual boundaries or impulse control. Although Ms. Doe's sexual orientation would be to adult males, she has no interest in engaging in sexual activity. Indeed, on tests that measure sexual concerns and behavior, Ms. Doe scored in the "zero" range.

SIGNED UNDER THE PENALTIES OF PERJURY THIS 16 DAY OF JANUARY, 2018.

Randi Ettner Ph.D

RANDI ETTNER, PH.D.

EXHIBIT A

RANDI ETTNER, PHD
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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
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
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 Weiss Memorial Hospital, Chicago IL

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-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

Gender dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, 2017.

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; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, 2015; Atlanta, 2016; Ft. Lauderdale, 2016; Washington, D.C., 2016, Los Angeles, 2017, Minneapolis, 2017, Chicago, 2017; Columbus, Ohio, 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

Ettner, R. Mental health evaluation. Clinics in Plastic Surgery. Elsevier, in press.

Ettner, R. Etiology of gender dysphoria in Schechter (Ed.) Gender Confirmation Surgery: Principles and Techniques for an Emerging Field. Springer, in press.

Ettner, R. Pre-operative evaluation in Schechter (Ed.) Surgical Management of the Transgender Patient. Elsevier, 2017.

Berli, J., Kudnson, G., Fraser, L., Tangpricha, V., Ettner, R., et al. Gender Confirmation Surgery: what surgeons need to know when providing care for transgender individuals. *JAMA Surgery*; 2017.

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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