EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ISIS BENJAMIN; FANTASIA HORTON; NAEOMI MADISON; BRYNN WILSON; and JOHN DOE; on behalf of themselves and all persons similarly situated, Plaintiffs, v. COMMISSIONER TYRONE OLIVER, in his official capacity; ASSISTANT COMMISSIONER RANDY SAULS, in his official capacity; STATEWIDE MEDICAL DIRECTOR DR. MARLAH MARDIS, in her official capacity; and CENTURION OF GEORGIA, LLC, Defendants.	Civ. Case No.1:25-cv-04470-VMC

DECLARATION OF RANDI ETTNER, Ph.D.

I, Randi Ettner, Ph.D., declare as follows based on my personal knowledge:

INTRODUCTION

1. My name is Dr. Randi C. Ettner and I am a clinical and forensic psychologist with 35 years of expertise concerning the diagnosis and treatment of gender dysphoria.

2. I have been retained by Plaintiffs' counsel to provide the Court with scientific information about gender dysphoria.

3. Specifically, I have been retained to explain the standard of care for, and medical necessity of, gender dysphoria treatment. I also have been retained to provide my expert opinion on the harms associated with denying or terminating gender dysphoria treatment without individualized consideration of medical necessity—as I understand Georgia Senate Bill 185 requires—particularly in the context of correctional institutions where access to healthcare for gender dysphoria has been limited.

4. I also provide an expert opinion on the inadequacy of psychotherapy and/or psychotropic drugs as an alternative to gender dysphoria treatment such as hormone therapy in patients for whom hormone therapy is medically indicated.

5. As I further explain below in my opinions, by blanketly prohibiting medically necessary gender-affirming care, without requiring individualized consideration of the medical needs of incarcerated individuals, GA SB185 endangers a uniquely vulnerable population within Georgia's prisons.

QUALIFICATIONS

6. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoria. 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. I am on the medical staff of Weiss Memorial Hospital in Chicago.

7. Since the late 1970s, I have evaluated, diagnosed, and/or treated over 3,000 individuals with gender dysphoria. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text titled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Routledge 2007), and the Second Edition (co-editors Monstrey & Coleman; Routledge, 2016). I am currently under contract to publish the Third Edition of this text. In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

8. The World Professional Association for Transgender Health (WPATH) is an international association of more than 2,000 medical and mental health professionals specializing in the treatment of gender diverse people that promulgates Standards of Care ("SOC") for the treatment of gender dysphoria worldwide. I was Secretary and served as a member of the Board of Directors of WPATH for more than a decade.

9. I am a co-author of WPATH's Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, Version 7 ("WPATH SOC-7"), published in 2012, and the WPATH Standards of Care for the Health of

Transgender and Gender Diverse People, Version 8 ("WPATH SOC-8"), published in 2022. For SOC-8, I was the co-lead for the chapter on "Applicability of the Standards of Care to People Living in Institutional Environments." I also chair the WPATH Committee for Institutionalized Persons.

10. As an expert on the treatment of gender dysphoria, I provide training to medical professionals on health care for incarcerated transgender people with gender dysphoria. I have also been a consultant to policy makers, as well as the Centers for Medicare and Medicaid, regarding appropriate care for incarcerated individuals with gender dysphoria.

11. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of Transgender Health and the International Journal of Transgender Health.

12. I have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, 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 U.S. Congress House of Representatives on February 5, 2019, recognizing my work for WPATH and my work relating to gender dysphoria in Illinois.

13. I have lectured throughout North America, Europe, South America, and Asia on topics related to gender dysphoria and have given grand rounds on gender dysphoria at university hospitals. I have been a consultant to news media and have been interviewed as an expert on gender dysphoria for hundreds of television, radio, and print outlets throughout the country.

14. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with gender dysphoria in prison settings, and been repeatedly qualified as an expert.

15. Over the past four years, I also have given expert testimony at trial or by deposition in the following cases related to gender dysphoria and its treatment: *Wagoner v. Dahlstrom*, No. 3:18-cv-00211-RRB (D. Alaska); *Bernier v. Turbocam*, No. 1:23-cv-00523-LM-AJ (D.N.H.); *Cordellioné v. Comm'r, Indiana Dep't of Corr.*, No. 3:23-cv-135-RLY-CSW, 2024 WL 4333152 (S.D. Ind. Sept. 17, 2024); *Soneeya v. Turco*, 717 F. Supp. 3d 132 (D. Mass. 2024); *Levy v. Green*, No. 18-1291-TDC, 2024 WL 3090367 (D. Md. June 21, 2024); *D.T. v. Christ*, 552 F. Supp. 3d 888 (D. Ariz. 2021); *Zayre-Brown v. North Carolina Dep't of Public Safety*, No. 3:22-cv-00191, 2024 WL 410243 (W.D.N.C. Feb. 2, 2024); *Roe v. Herrington*, No. 4:20-cv-00484-JAS, 2023 WL 5759590 (D. Ariz. Aug. 10, 2023); *Diamond v. Ward*, No. 5:20-cv-00453, 2022 WL 3221224 (M.D. Ga. Aug. 9, 2022); *Stillwell v.*

Dwenger, No. 1:21-cv-1452-JRS-MPB, 2021 WL 12323941 (S.D. Ind. June 7, 2021); *Letray v. City of Watertown*, 718 F. Supp. 3d 192 (N.D.N.Y.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB, 2021 WL 12192011 (W.D. Wash. Nov. 2, 2021); *Gilbert v. Dell Technologies*, 415 F. Supp. 3d 389 (S.D.N.Y. 2019); *Kadel v. Folwell*, 620 F. Supp. 3d 339 (M.D.N.C. 2022); *Iglesias v. Connor*, No. 19-cv-0415-RJN, 2021 WL 4943739 (S.D. Ill. Oct. 22, 2021); *Monroe v. Wexford Health Sources, Inc.*, No. 18-CV-01052 (S.D. Ill. Sept. 2, 2021); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc, 2021 WL 3412445 (W.D. Tenn. Aug. 4, 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033, 2021 WL 7285897 (N.D. Iowa Aug. 13, 2021); *Claire v. Florida Dep't of Mgmt. Servs.*, 504 F. Supp. 3d 1328 (N.D. Fla. 2020); *Williams v. Allegheny Cnty.*, No. 2:17-cv-01556-MJH, (W.D. Pa. 2021); *Gore v. Lee*, No. 3:19-CV-00328, 2023 WL 4141665 (M.D. Tenn. June 22, 2023); *Eller v. Prince George's Cnty. Public Sch.*, 580 F. Supp. 3d 154 (D. Md. 2022); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB, 2019 WL 2409572 (S.D. Ill. June 7, 2019); *Ray v. Acton*, No. 2:18-cv-00272, 2020 WL 11222226 (S.D. Ohio Jan. 9, 2020); *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103 (D. Idaho 2018).

16. My clinical consulting fee is $400 per hour.

17. A true and correct copy of my Curriculum Vitae, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as **Appendix A.**

MATERIALS CONSIDERED

18. In preparing this declaration, I relied on my extensive professional and clinical experience and the body of scientific and medical literature, including my own, concerning gender dysphoria.

19. A full list of the Materials I considered in forming my opinions is attached hereto as **Appendix B**. The Appendix includes medical and scientific materials related to transgender people and gender dysphoria that I relied on to draft this declaration.

BACKGROUND ON GENDER DYSPHORIA

20. The term "gender identity" is a well-established concept in psychology and medicine, referring to one's internal sense of oneself as belonging to a particular gender. Every person has a gender identity. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female.

21. At birth, infants are typically classified as male or female, based on a cursory view of the newborn's genitalia. This classification becomes the person's birth-assigned sex. Typically, persons born with the external physical characteristics

of males psychologically identify as men, and those with the external physical characteristics of females psychologically identify as women. However, for transgender people, this is not the case. For transgender people, the sense of one's self—one's gender identity—differs from their birth-assigned sex, giving rise to a sense of being "wrongly embodied."

22. The only difference between transgender people and non-transgender people is that the latter have a gender identity that is consistent with their birth-assigned sex whereas the former do not. A transgender woman cannot simply turn off her gender identity like a switch any more than anyone else could.

23. For some individuals, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in gender dysphoria, a serious medical condition characterized by clinically significant, persistent feelings of stress and discomfort with one's assigned gender.

24. In 1980, the American Psychiatric Association ("APA") introduced the diagnosis gender identity disorder ("GID") in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The GID diagnosis 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.

25. In 2013, with the publication of DSM-5, the GID 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.

26. The DSM-5 explained that the former GID diagnosis connoted "that the patient is 'disordered.'" Am. Psych. Assoc., *Gender Dysphoria* (Nov. 15, 2023), https://dictionary.apa.org/gender-dysphoria; *see also* Am. Psych. Assoc., *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) (hereinafter "DSM-5"). 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. DSM-5 at 512.

27. 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 the DSM prior to 2013, GID was 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, in 2013, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own.

28. Similarly recognizing that being transgender is not a mental illness, the World Health Organization ("WHO") likewise reclassified the gender incongruence diagnosis in the International Classification of Diseases-11 ("ICD-11"), removing gender incongruence from the chapter on mental and behavioral disorders.

29. Gender dysphoria is both the name of the formal psychological diagnosis and the psychiatric term for the severe and unremitting emotional pain that the condition gives rise to.

30. Everyone with a gender dysphoria diagnosis falls under the umbrella of transgender. For that reason, the terms are often used interchangeably.

31. The diagnostic criteria for gender dysphoria in 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.

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.

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 (DSM-5 at 452-453).

THE BIOLOGICAL BASIS OF GENDER DYSPHORIA

32. The DSM-5 now includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to gender dysphoria (DSM-5 at 457).

33. Gender dysphoria is increasingly understood to arise, at least in part, from identifiable biological and physiological mechanisms. A growing body of research demonstrates that gender identity is influenced by a combination of genetic, hormonal, neurodevelopmental, and epigenetic factors—affirming that gender dysphoria is not merely psychological or social in origin.

34. As evidenced throughout the scientific and medical literature, gender identity has a strong biological basis and a physiological and biological etiology. For example, 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. (Rametti *et al.*, White Matter, 2011; Rametti *et al.*, Microstructure, 2011; Luders *et al.*, 2006).

35. Biological differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain (Guillamon, *et al.*, 2016). The right hemisphere 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. Attached as **Appendix C** is a table depicting the brain areas that differ (Rametti, *et al.*, 2011).

36. It is now believed that gender dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one peer-reviewed paper noted that:

a. [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. Current evidence strongly supports a predominantly biological basis for gender identity over postnatal social influence. (Garcia-Falgueras, A. & Swaab, D., 2010).

37. 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." (Hare, L. *et al.*, 2009).

38. Family and twin studies suggest a heritable component to gender incongruity. For example, Gomez-Gil *et al.* (2010) found that siblings of transgender individuals were four times more likely to also be transgender than the general population.

39. Twin studies by Diamond (2013) and Heylens *et al.* (2012) found greater concordance for gender dysphoria among monozygotic twins (identical) compared to dizygotic twins (fraternal), supporting a genetic contribution. Green and Keverne (2000) found that transgender women had similar genetic patterns on their mother's side, implicating the X chromosome.

40. At the molecular level, genetic polymorphisms in androgen and estrogen receptor genes (AR, ERα, ERβ), as well as steroidogenic enzymes such as CYP19, have been associated with gender incongruity (Henningsson *et al.*, 2005; Bentz *et al.*, 2008; Hare *et al.*, 2009; Fernandez *et al.*, 2014a, 2014b, 2018; D'Andrea *et al.*, 2020). These findings suggest functional differences in how sex hormones are received and processed. Complementary epigenetic studies have shown differential DNA methylation in transgender individuals compared to cisgender controls, including in genes regulating estrogen sensitivity (Fernandez *et al.*, 2020; Ramirez *et al.*, 2021).

41. Prenatal hormonal influences have also been implicated. Exposure to substances such as phenobarbital (long-acting sedative and anti-seizure) drugs or

endocrine-disrupting chemicals has been shown to affect fetal brain organization and later gender identity development (Dessens *et al.*, 1999; Colborn *et al.*, 1996; Swaab, 2004). Physical markers like digit ratios, which reflect prenatal androgen exposure, differ between transgender and cisgender individuals in predictable ways (Schneider *et al.*, 2006).

42. Brain imaging and anatomical studies have found that transgender individuals often exhibit structural characteristics in regions such as the bed nucleus of the stria terminalis (BNSTc), which is the part of the brain that is linked to gender; the hypothalamus; and the cortex that align more closely with their experienced gender than with their assigned sex at birth (Zhou *et al.*, 1995; Kruijver *et al.*, 2000; Garcia-Falgueras, A. & Swaab, D., 2008; Taziaux *et al.*, 2012; Luders *et al.*, 2006; Shaw *et al.*, 2008; Berglund *et al.*, 2008).

43. Taken together, these findings underscore that gender dysphoria arises from complex biological and physiological underpinnings, and that gender dysphoria is accurately described as a condition that results from physical and biological impairments.

44. Because gender identity has a biological basis, efforts to change an individual's gender identity are therefore both futile and contrary to clinical standards of care, which recognize treatment for gender dysphoria as medically necessary. Past attempts to "cure" transgender individuals by means of

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

THE STANDARD OF CARE FOR THE TREATMENT OF GENDER DYSPHORIA REQUIRES INDIVIDUALIZED MEDICAL TREATMENT

45. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated. As set forth below, 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. (Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013); Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014); American Psychiatric Association. (2022)).

46. The SOC, first published in 1979, set forth medically accepted standards of care for treatment of gender dysphoria. (Coleman, E., Radix, A. E., Bouman, W. P., *et al.* (2022)).

47. The Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (2017) ("Endocrine Society Guidelines"), an evidence-based guideline for the hormonal treatment of

transgender persons that was formulated using the Grading of Recommendations, Assessment, Development, and Evaluation ("GRADE") system, provide authoritative clinical guidance on the administration of hormone therapy to gender dysphoric patients by primary care physicians, endocrinologists, and other medical providers. (Hembree, W. C., *et al.*, 2017).

48. The SOC and the Endocrine Society are the internationally recognized guidelines for the treatment of persons with gender dysphoria and inform medical treatment throughout the world.

49. 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 National Commission on Correctional Healthcare all endorse protocols in accordance with the SOC and Endocrine Society Guidelines. *See*, *e.g.*, Am. Med. Assoc., House of Delegates Resolution 122 (A-08) (2008), https://www.tgender.net/taw/ama_resolutions.pdf; Wylie C. Hembree, *et al.*, Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, J. Clinical Endocrinology & Metabolism 3132 (2009); B.S. Anton, Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the

Council of Representatives, 64 Am. Psych. 372 (2008), https://www.apa.org/about/policy/transgender.pdf.

50. The accepted clinical standards for the treatment of gender dysphoria explicitly call for individualized assessment and treatment planning based on diagnosis, patient goals, comorbid conditions, and response to care (Hembree, W.C. *et al.*, 2017).

51. As part of the SOC, many transgender individuals with gender dysphoria undergo a medically indicated and supervised gender transition by qualified medical and mental health providers in order to ameliorate their gender dysphoria and live life consistent with their gender identity. Like all medical guidelines, 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, as further detailed below: **hormone therapy** to feminize or masculinize the body; **surgery** to change primary and/or secondary sex characteristics; and **changes in gender expression and role.** (WPATH SOC-8).

52. Once a diagnosis of gender dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

53. While specific treatment pathways may vary, the overarching goal is the same: to relieve the clinically significant distress that characterizes gender dysphoria when it is left inadequately treated.

54. In the treatment of gender dysphoria, or indeed any medical condition, it is inconsistent with accepted medical practice to make categorical determinations about the availability of care without assessing the individual needs of the patient. Sound clinical judgment requires providers to evaluate each case on its own merits, taking into account the patient's medical history, current condition, and the risks and benefits of treatment options. Blanket policies that preclude such individualized assessment undermine the foundational principles of evidence-based care.

55. Broad per se policies restricting or denying particular types of gender dysphoria care to individuals in prisons—like a refusal to provide hormones or gender affirming surgery under any circumstances—are inconsistent with the SOC and the requirements to provide medical treatment based on each individual's medical needs. *See* WPATH SOC-7 at 68 ("Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC."); WPATH SOC-8 at S107 ("The denial of medically necessary evaluations for and the provision of gender affirming surgical treatments and necessary aftercare [in institutional settings] is inappropriate and inconsistent with these Standards of Care.").

56. It is medically inappropriate—and potentially dangerous—to make blanket decisions about treatment for individuals without accounting for each patient's unique medical history, psychological profile, symptom presentation, and treatment response. Like other medical conditions, gender dysphoria varies in severity and expression, and therefore demands individualized assessment and care.

57. Clinical guidelines underscore that once gender dysphoria is diagnosed, treatment must be based on a comprehensive evaluation of the patient's current medical and psychological needs. The SOC explicitly state that treatment for incarcerated individuals should mirror community-based protocols, just as the management of diabetes or hypertension in prison is expected to meet the same standard as treatment outside of prison.

58. No two individuals experience gender dysphoria in exactly the same way. People differ in their symptom profiles, hormone levels, comorbid conditions, and overall treatment needs. Policies that ignore these individual factors and deny appropriate care are not only medically unjustifiable but are likely to result in a cascade of adverse outcomes—including psychological decompensation, self-harm, and suicidality.

59. The medical necessity of individualized treatment for gender dysphoria is even more pronounced in carceral settings. Having evaluated prisoners in 21 states and 53 institutions throughout the US, I have witnessed extraordinary

transformations in patients who are provided with appropriate gender-dysphoria medical care. Depression, anxiety, suicidality and self-harm are often significantly reduced, or entirely eliminated. The increased self-esteem and improved emotional regulation often result in rehabilitation or parole suitability for these patients.

THE NECESSITY OF QUALIFIED PROFESSIONAL TO DIAGNOSE AND TREAT GENDER DYSPHORIA

60. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with gender dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and continuing education in the assessment and treatment of gender dysphoria.

61. Importantly, the SOC require that "[m]ental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria." SOC-7 at 23; *see*

also SOC-8 at S34 (providers should "[h]ave experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.").

62. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of gender dysphoria, or the mentorship and supervision of an expert in this field. Particularly in the prison setting, where individuals lack agency, it is imperative that providers have had experience evaluating patients for gender affirming medically indicated interventions, expertise and experience necessary to provide care in this specialized area of medicine.

63. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care, or place patients at significant risk of deterioration of functioning, psychological decompensation, surgical self-treatment, or suicidality.

64. Incarcerated patients with gender dysphoria will have a range of needs and may require services if housed in restricted placements. Mental health support and access to hormone therapy must be continued without interruption. Prolonged isolation can exacerbate gender dysphoria and suicidal ideation. Regular checks with

qualified mental health providers are critical. Access to gender-affirming clothing, hygiene products, and other gender affirming items remain important.

TREATMENT MODALITIES FOR GENDER DYSPHORIA

HORMONE THERAPY

65. The Standards of Care establish that for individuals with persistent, well-documented gender dysphoria, hormone therapy is often an effective, essential, and medically necessary treatment. *See* SOC-7 at 33 ("Feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender non-conforming individuals with gender dysphoria. . . ."); SOC-8 at S110 ("Transgender and gender diverse . . . persons may require medically necessary gender-affirming hormone therapy . . . to achieve changes consistent with their embodiment goals, gender identity, or both. . . .").

66. Hormone therapy is a well-established and effective means of treating gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that hormone therapy in accordance with the WPATH Standards of Care is medically necessary treatment for many individuals with gender dysphoria. AMA 2019; APA 2018; The Endocrine Society 2020.

67. The goals of hormone therapy for individuals with gender dysphoria are: (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth; and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone treatment developed for hypogonadal patients (i.e., non-transgender males born with insufficient testosterone or non-transgender females born with insufficient estrogen).

68. The therapeutic effects of hormone therapy are twofold: (i) with endocrine 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; and (ii) hormones act directly on the brain, via receptors sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of an improved sense of well-being. (Hembree *et al.*, 2017).

69. Testosterone therapy also plays a central role in the treatment of gender dysphoria in transgender men. It induces masculinizing physical changes that typically include deepening of the voice, cessation of menses, increased muscle mass, redistribution of body fat to a male-typical pattern, growth of facial and body hair, and clitoral enlargement. These effects help to reduce the incongruence

between a trans man's physical appearance and gender identity, often leading to marked improvements in psychological well-being, self-esteem, and social functioning. Numerous studies have documented that initiation of testosterone is associated with reductions in anxiety, depression, and suicidal ideation among transmasculine individuals (Murad *et al.*, 2010; Olson-Kennedy *et al.*, 2016). Testosterone therapy also reduces the intensity of gender dysphoria itself, particularly when menstruation and other feminizing features are suppressed. For many transgender men, hormone therapy is not elective—it is essential, medically indicated treatment that supports core aspects of identity and daily functioning.

70. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals with a gender dysphoria diagnosis who had received hormones and compared them with a group of transgender individuals with a gender dysphoria diagnosis who did not. Untreated individuals showed much higher levels of depression, anxiety, and social distress than those who received hormone therapy. (*See* Rametti, *et al.*, 2011; Colizzi *et al.*, 2014; Gorin-Lazard *et al.*, 2014; Gorin-Lazard *et al.*, 2011).

71. In my clinical experience, hormone therapy produces consistent psychological and physiological improvements. Individuals who receive medically-indicated hormones experience a previously unknown level of well-being—

profound psychological relief and emotional stabilization. For these individuals, the alignment of physical characteristics with gender identity can result in a sense of congruence, comfort in one's body, and mental clarity that had not previously been attainable.

72. This improvement often includes reduced anxiety and depression, increased self-esteem, and enhanced capacity for social, occupational, and emotional functioning—levels of well-being they had not known prior to treatment. It is not hyperbole to describe the impact of this medical treatment as "life-altering." The realization that one has lived as a "false self," through no fault of one's own, kindles a tectonic shift in mood, mental health and behavior. This is particularly dramatic in the case of incarcerated people.

SURGICAL TREATMENT FOR GENDER DYSPHORIA

73. For some individuals with severe gender dysphoria, hormone therapy alone is insufficient; true relief requires surgical intervention to align primary sex characteristics with their experienced gender.

74. Whether surgical intervention is medically indicated for some individuals with gender dysphoria must be determined through individualized clinical assessment.

75. Multiple studies have confirmed that gender-affirming surgeries—such as vaginoplasty, phalloplasty, orchiectomy, and chest reconstruction—are

associated with significant, long-term improvements in psychological well-being, quality of life, and reductions in depression and suicidality (van de Grift *et al.*, 2018; Ardebili *et al.*, 2020; de Vries *et al.*, 2014; Shelemy *et al.*, 2024). This body of evidence supports the consensus that these interventions are medically necessary, not elective.

76. Given the extensive empirical support for surgical treatment of gender dysphoria, it is misleading and clinically inaccurate to characterize such interventions as "experimental."

77. Version 7 of the WPATH Standards of Care states: "While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. . . . For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity." WPATH SOC-7 at 54-55.

78. Version 8 of the WPATH Standards of Care similarly states: "Medically necessary gender-affirming interventions are discussed in SOC-8. These include but are not limited to . . . genital reconstruction, for example, phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty. . . [and] hair removal from the face, body,

and genital areas for gender affirmation or as part of a preoperative preparation process. . . . Access to assessment and treatment for [transgender] people seeking [gender-affirming medical and/or surgical treatments] is critical given the clear medical necessity of these interventions and the profound benefits they offer to [transgender] people." WPATH SOC-8 at S18, S32.

79. Genital reconstruction surgery for transgender women serves two primary therapeutic purposes. First, orchiectomy (removal of the testicles) eliminates the body's principal source of testosterone, reducing the need for high-dose anti-androgen medications. Second, vaginoplasty facilitates somatic congruence, enabling the individual's body to align more closely with their gender identity. This congruence—particularly of the genitalia—is often essential to alleviating severe gender dysphoria. In addition, breast augmentation and permanent hair removal (e.g., electrolysis or laser treatment) are medically indicated for many transgender women to address dysphoria related to secondary sex characteristics (WPATH, 2022; van de Grift *et al.*, 2018).

80. Surgical care can be equally critical for transgender men. Chest reconstruction surgery (bilateral mastectomy and chest contouring) significantly reduces dysphoria related to unwanted breast tissue and allows for social integration without constant concealment or binding (Gorin-Lazard *et al.*, 2012; Morrison *et al.*, 2021). For individuals whose dysphoria centers on genital

incongruence, hysterectomy, oophorectomy, metoidioplasty, or phalloplasty may be necessary. These procedures help achieve alignment with gender identity by removing reproductive organs associated with the sex assigned at birth and constructing genitalia that are more typical of cisgender men.

81. Surgical interventions in transmasculine individuals have been associated with improvements in self-esteem, psychological functioning, and quality of life (van de Grift *et al.*, 2020; Ardebili *et al.*, 2020). When clinically indicated, these procedures are not cosmetic or elective—they are essential to relieve suffering, reduce suicidality, and support mental health.

SOCIAL TRANSITION AND GENDER AFFIRMATION

82. Gender dysphoria, like many medical conditions, often requires more than a single intervention for effective treatment. For many individuals with gender dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called "social transition," are an important, and medically necessary, part of treatment for the condition. Such social transition extends beyond physical attributes to encompass social gender presentation and the signifiers that shape interpersonal recognition and identity validation. Aligning outward gender expression with internal identity is a core element of established medical treatment for gender dysphoria (see, e.g., WPATH, 2022).

83. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity and the use of gender-congruent pronouns. Through this social transition, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. (Greenberg & Laurence 1981; Ettner 1999; Devor 2008). Clothing and grooming items are particularly important for individuals who have initiated hormone therapy, since the physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort.

84. Social transition care is a critical, clinically appropriate component in the medical treatment of gender dysphoria in many patients because it fosters alignment between internal identity and outward appearance, which is essential for psychological well-being, thereby alleviating dysphoria and enhancing psychological well-being. (Greenberg & Laurence 1981; Ettner 1999; Devor 2008).

85. Accordingly, social transition care is considered to be important, therapeutic medical treatment by clinicians and the SOC—one that has been shown to reduce psychopathology, depression, suicide attempts, and symptoms of posttraumatic stress disorder (PTSD), based on over thirty years of research. (Greenberg & Laurence 1979; Sevelius 2013).

86. The SOC also specifically provide that hair removal, the elimination of a visible secondary sex characteristic in transgender women, prosthetic devices, and gender-affirming items, such as bras and panties for transgender women, can be significant and integral to alleviating gender dysphoria symptoms (WPATH SOC-8).

87. Similarly, national survey data confirm that access to these affirming interventions significantly reduces depression, anxiety, and suicidality among transgender individuals (James *et al.*, 2016).

88. For transgender men specifically, the ability to present as male in social, occupational, and institutional settings, including prisons, supports emotional stability and reduces psychological distress. (Peitzmeier *et al.*, 2017).

89. Other gender-appropriate grooming items such as feminine deodorant, moisturizer, hair care, and make-up may also be necessary components of treatment. These accoutrements are critical to the social transition and mental wellbeing of gender dysphoric people.

90. These clothing and grooming items are particularly important to provide to transgender patients who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender

women, female undergarments allow genitals to be tucked[1] and less visible, reducing symptoms of gender dysphoria.

91. Similarly, bras are an important component of gender congruent clothing. Wearing a bra produces a feeling of congruence as breasts are a visible female secondary sex characteristic. When breast growth results from gender affirming hormone treatment, bras provide physical support, reduce discomfort, and protect sensitive breast tissue as it grows.

92. Thus, social role transition has an enormous impact in the treatment of gender dysphoria. An early seminal study emphasized the importance of aligning presentation and identity and the benefits to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals 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 presenting in their birth-assigned sex role. (Greenberg & Laurence 1981).

93. More recently, Sevelius (2013) proposed a "gender affirmation model" which demonstrated that access to gender affirming components of social role

[1] The process of tucking involves repositioning the testes into the inguinal canals (where they naturally descend from during fetal development) and securing the penis between the legs or toward the rear. This helps achieve a smoother, flatter appearance in the groin area, promoting a more traditionally feminine body contour. Reducing the visibility of the genitals is therapeutic, as viewing "inappropriate genitals" is abhorrent and increases symptoms.

transition equated with better mental health, fewer suicide attempts, and lower levels of depression and posttraumatic stress disorder ("PTSD") symptoms.

94. In both transgender women and men, access to gender-affirming social transition is a vital component of comprehensive treatment, not an optional or cosmetic measure.

GENDER DYSPHORIA AND PSYCHOTHERAPY

95. There are no psychotherapeutic interventions that have been demonstrated to be effective in alleviating gender dysphoria itself, and such interventions are not a substitute for medical intervention where medical intervention is needed. Nor are they preconditions for such intervention.

96. Psychiatric medications and treatments aimed primarily at the symptoms of anxiety or depression—e.g. anxiolytics, selective serotonin reuptake inhibitors, or mood-stabilizing psychotropic medication—are not considered gender dysphoria treatment because they do not resolve the clinically-significant distress that patients with gender dysphoria experience due to the incongruence between their gender identity and birth-assigned sex.

97. Likewise, while psychotherapy or counseling can provide support and help with the personal and social aspects of a gender transition and may to some extent lessen conditions such as depression and anxiety, they are not a substitute for medical interventions that directly address the underlying dysphoria. American

Psychological Association, 2015, Guidelines for Psychological Practice With Transgender and Gender Nonconforming People. *Am Psychol* 70(9):832–864. By analogy, in type one diabetes, counseling might provide psychoeducation about living with a chronic condition and information about nutrition, but it does not obviate the need for insulin.

GENDER DYSPHORIA AND CO-OCCURRING MENTAL HEALTH CONDITIONS

98. Too often, patients are denied medically indicated gender-affirming treatment due to a co-occurring mental health diagnosis such as a personality disorder or other mental health condition. However, a co-occurring psychiatric diagnosis does not categorically contraindicate gender-affirming care (Bouman *et al.*, 2016). Personality disorders, for example, are characterological and considered to be lifelong.[2] Under the WPATH Standards of Care Version 8, the presence of such conditions warrants careful assessment and stabilization, but does not preclude care unless the person is unable to consent or is actively psychotic (WPATH SOC-8).

99. Treating other co-occurring symptoms like depression and anxiety is not a substitute for treating gender dysphoria, as these symptoms are often

[2] Borderline personality disorder ("BPD") can be difficult to diagnose and can be particularly challenging in a prison environment. Symptoms are subjective and can vary widely in severity and frequency, complicating clinical assessments. BPD shares symptoms with other conditions such as mood disorders, anxiety, PTSD, etc. Stressful environments, such as prisons, can exacerbate BPD symptoms, complicating the differentiation between a personality disorder and situational reactions.

downstream effects of the underlying dysphoria being untreated or undertreated. Numerous studies have found that once gender dysphoria is properly addressed through medical transition, secondary mental health symptoms frequently resolve or diminish substantially (Heylens *et al.*, 2014; Dhejne *et al.*, 2016). Thus, mental health conditions unrelated to untreated gender dysphoria should be addressed concurrently. Just as a physician would simultaneously manage comorbid conditions like hypertension and pneumonia, mental health professionals should treat co-occurring psychiatric issues in parallel with medically necessary gender-affirming care (Hembree *et al.*, 2017; Fraser *et al.*, 2010).

THE STANDARDS OF CARE IN CORRECTIONAL SETTINGS

100. 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 conditions, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the SOC expressly state that all elements of the prescribed assessment and treatment of gender dysphoria are equally applicable to patients in prison.

101. Version 7 of the SOC, for example, provided that "The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation," and "[h]ealth care for transsexual, transgender, and gender nonconforming people living in an institutional

environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community." WPATH SOC-7 at 67. It further emphasized that "[a]ccess to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements." *Id.*

102. Version 8 of the SOC expanded the discussion of adequate care for incarcerated transgender individuals and emphasizes that "[a]ll of the recommendations of the Standards of Care apply equally to people living in . . . institutions. People should have access to these medically necessary treatments irrespective of their housing situation within an institution." (WPATH SOC-8 at S104).

103. The National Commission on Correctional Health ("NCCHC") has long recommended treatment in accordance with the SOC for people in correctional settings. In 2009, the NCCHC adopted a Position Statement providing in relevant part that "[t]he management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards that have been developed by professionals with expertise in transgender health," referring expressly to the WPATH SOC. (NCHC 2009). The 2009 position statement also emphasized that "[d]etermination of treatment necessary for transgender patients should be on a case-by-case basis," and "[w]hen determined to be medically necessary for a particular inmate, hormone therapy

should be initiated and sex reassignment surgery considered on a case-by-case basis." *Id.* The NCCHC reaffirmed and expanded this position statement in 2015.

104. The most recent NCCHC Position Statement on transgender care was published in 2020, and reaffirmed and expanded on the NCCHC's prior position, including identifying the WPATH SOC as the standard of care in a correctional setting. In relevant part the Statement provides that "[e]valuations to determine the medical necessity of gender-affirming surgical procedures will be performed on a case-by-case basis, applying a careful risk, benefit, and alternatives analysis. Gender-affirming procedures will be provided when determined to be medically necessary for a patient according to accepted medical standards." (NCHC 2020).

EXPERT OPINIONS RE GEORGIA SB185: HARMS OF TREATMENT DENIAL OF WITHDRAWAL IN GEORGIA'S CARCERAL SETTINGS

105. Georgia Senate Bill 185 ("SB185"), which was signed into law on May 8, 2025, prohibits gender dysphoria treatment including hormone therapy, cosmetic procedures and prosthetics, and surgery in state correctional institutions.

106. For the purposes of offering my expert opinion in this matter, I assume the statute has the following effect:

a. The law prohibits the state provision of the aforementioned treatments to all incarcerated persons with gender dysphoria, even when the

treatment was previously provided to patients as medically necessary by correctional healthcare officials;

b. The law prevents anyone newly diagnosed with gender dysphoria from being evaluated for, or initiating, care;

c. The law includes no exceptions for patients already receiving hormone therapy as treatment for their gender dysphoria; instead, the law provides for the tapering off of hormonal therapy that was initiated prior to the law's effective date for those incarcerated patients, only to facilitate permanent discontinuation.

107. For the purposes of offering my expert opinion in this matter, I also assume the following to be true about GDC's plan to implement SB185:

a. The plan to implement SB185 provides for the forced termination of hormone therapy for patients with gender dysphoria over a four-to-eight-week period or, at a maximum, a three-month period.

b. Under the plan, all patients with gender dysphoria who previously received hormone therapy will be notified that their hormone therapy is being terminated sometime in July 2025.

c. Under the plan, a medical provider will obtain "informed consent" for one of two options, both of which result in the termination of a patient's prescribed hormone therapy for non-medical reasons. Under the first

option, patients' hormone therapy will be immediately terminated. Under the second option, patients will have their hormone therapy gradually terminated over a four-to-eight-week period.

d. Thereafter, all gender dysphoria patients will have their hormone therapy care terminated by October 3, 2025, with many projected to have their hormone therapy terminated earlier.

e. The plan to implement SB185 calls for "increased access to counseling" for those whose hormone therapy is terminated.

f. The plan to implement SB185 calls for four mental health follow-up appointments and three physical health follow-up appointments throughout the hormone therapy termination process.

g. Consistent with SB185, the plan to implement SB185 includes no exceptions to termination of hormone therapy for those previously receiving hormone therapy due to a gender dysphoria diagnosis.

SB185 CONFLICTS WITH ACCEPTED CLINICAL STANDARDS BY BARRING INDIVIDUALIZED MEDICAL TREATMENT BASED ON PATIENT NEED

108. Assuming the law as implemented by GDC has the stated effect, SB185 prohibits medical interventions that are well-established as effective, necessary components of treatment for patients with gender dysphoria, mandating their denial irrespective of patient medical needs.

109. This categorical denial of healthcare for patients with gender dysphoria stands in direct conflict with established medical standards, including those from the WPATH, the Endocrine Society, and the American Medical Association, and constitutes a dangerous deviation from evidence-based healthcare.

110. SB185 also undermines the principle of individualized care by preventing medical providers from using individualized clinical judgment when treating gender dysphoric patients.

111. For instance, SB185 prohibits Georgia medical providers from exercising clinical judgment in determining who requires hormone therapy, how it should be initiated or continued, and what monitoring is needed. By substituting a blanket rule for individualized treatment, the law prevents providers from delivering care consistent with medical necessity.

112. SB185 also prohibits surgery as well as evaluations for surgery—foreclosing individualized gender dysphoria treatment based on medical judgment and patient need—even though surgical procedures such as vaginoplasty, chest surgery, or orchiectomy may be medically necessary healthcare for those who do not respond to hormonal treatment alone. In doing so, the law denies care to patients for whom surgical intervention is the only effective remedy, regardless of the severity or persistence of their symptoms.

113. Social transition is recognized as a clinically appropriate aspect of individualized treatment for gender dysphoria, regardless of whether medical or surgical interventions are pursued.

114. Thus, for incarcerated individuals, the removal of social transition items under the SB185 Enforcement Plan is not a benign decision—it constitutes a medically unjustifiable disruption of care. In an environment where autonomy and safety are already compromised, withholding gender-affirming social transition items enacts a form of institutionalized gender invalidation. This can be especially traumatizing for individuals with prior histories of discrimination.

115. And even though many patients require non-pharmacological interventions, such as hair removal or gender-affirming prosthetics, as part of their therapeutic medical treatment for their gender dysphoria, SB185 blanketly eliminates the possibility of the provision of this care and imposes a categorical denial, in conflict with professional standards calling for individualized patient care.

116. Furthermore, the foreseeable consequences of a policy that discontinues medically necessary treatment, as SB185 does, are severe. An outdated "freeze-frame" approach, in which hormone therapy is automatically halted or never adjusted during incarceration, has been widely recognized as clinically inappropriate and harmful (Brown, 2010; Mauri, 2011).

117. Thus, although it is never clinically appropriate to discontinue medically necessary treatment for non-medical reasons under the accepted standards of care, the State's proposed policy of uniformly tapering all transgender incarcerated persons off hormone therapy over a 4–8 week period carries additional foreseeable harm, as this fixed tapering schedule fails to consider individual dosage, duration of treatment, psychological vulnerabilities, or the potential for severe destabilization unique to each patient. For GDC patients with gender dysphoria, even a gradual taper will risk a resurgence of dysphoria, depression, or suicidality—effects that may be irreversible or life-threatening and which cannot be effectively resolved with psychotherapy or other mental health treatment as a replacement for hormone therapy, surgery, or social transition, as I explain further below.

118. Moreover, the idea, under SB185, that incarcerated transgender individuals can provide "informed consent" to the discontinuation of medically necessary care—under conditions where such care is being categorically terminated by the state—goes against clinical standards.

119. Informed consent presumes that a patient is presented with reasonable, evidence-based treatment options and is free to choose among them without coercion or constraint. When gender dysphoria patients are told they must discontinue hormone therapy, either immediately or through a tapering schedule, the "choice" offered is not between viable treatment alternatives, but between two forms of

medically contraindicated withdrawal. This is not informed consent in a clinical sense; it is a forced elimination of medically necessary treatment, contrary to the accepted standards of care and established clinical practices.

120. Likewise, SB185's plan to increase access to counseling to compensate for the forced withdrawal of medically necessary hormone therapy violates accepted clinical standards of care and practice in psychology for incarcerated persons with gender dysphoria. Counseling cannot reverse or mitigate the physiological and psychological consequences of discontinuing hormone therapy in patients for whom it is medically indicated.

121. As I explain above, hormone therapy is not a discretionary or elective intervention in these cases; it is a core component of the treatment of gender dysphoria, with well-documented benefits for mood stabilization, reduction in suicidality, improved functioning, and decreased psychological distress in patients who receive it. Thus, the serious risks that are likely to rise from forced withdrawal under S185—including increased dysphoria, anxiety, depression, irritability, and physiological symptoms such as fatigue and muscle loss that I discuss more fully below—are not issues that can be fully resolved or clinically alleviated through the mental health therapy that SB185's plan offers to individuals affected by SB185.

122. Moreover, SB185's plan to offer counseling in the wake of forced medical withdrawal does not constitute a therapeutic response and is not a substitute

for care. Nor will it mitigate the predictably grave clinical outcomes that SB185 will have in gender dysphoric patients, due to its categorical elimination of medically necessary care. In this way, the law is akin to offering psychological support to a diabetic patient whose insulin has been discontinued, or to a patient with epilepsy who has had anticonvulsants withdrawn. Counseling cannot address the underlying medical destabilization.

123. SB185's categorical denial and termination of gender-dysphoria treatment without any independent professional judgment, based on a blanket ban, violates the accepted community standards of care, which require that treatment decisions be made by competent professionals and individualized to patient needs. Gender dysphoria is no exception.

THE ENFORCEMENT OF SB185 WILL CAUSE SIGNIFICANT, PREVENTABLE HARM TO INCARCERATED PATIENTS

124. In my expert opinion, by denying incarcerated individuals the ability to be evaluated for, or to receive, medically necessary gender dysphoria treatment, SB185 will result in severe and predictable psychological and physical harm.

125. In my clinical experience and as peer-reviewed scientific literature corroborates, when transgender people are barred from receiving or even being assessed for gender dysphoria treatment such as hormone therapy, hair removal treatment, or surgical care, it results in prolonged psychological suffering; risk of psychological decompensation; and increased risks of suicidality, self-harm, and

physical injury up to and including death. (Coleman, E., *et al.*, 2022; Radix *et al.* 2016).

126. There is no clinical justification for discontinuing hormone therapy in patients who have a diagnosis of gender dysphoria and are benefiting from treatment. In my clinical experience, the predictable consequences of discontinuation include worsened psychological distress, heightened anxiety and depression, and a range of physiological withdrawal symptoms. In many cases, these effects can lead to a risk of serious psychological decompensation and may actively precipitate disease processes—such as hypertension, metabolic dysregulation, or major depressive episodes—that were previously stable or absent during treatment.

127. This harm is especially grave and foreseeable in carceral settings, where transgender people are uniquely vulnerable, as earlier discussed, and medically dependent on uninterrupted care provided by and within the correctional facility where they are imprisoned (American Medical Association 2018; Brown 2010).

128. The harms of treatment denial are magnified within correctional environments. Prisons are inherently stressful, isolating settings that compromise mental health even in the general population. They are characterized by:

a. High baseline rates of depression, anxiety, and psychological distress (Haney 2003);

b. Limited privacy and constant gendered surveillance, which is acutely distressing for transgender individuals whose appearance or anatomy may not align with institutional housing assignments (James *et al.*, 2016); and

c. Delayed, restricted, or inaccessible psychiatric and medical services, particularly for stigmatized conditions such as gender dysphoria (Mann 2006; Brown 2009).

129. In this context, transgender individuals face disproportionately high risks of deterioration, psychological decompensation, and suicide. Multiple studies have documented that transgender people in custody experience elevated rates of suicidal ideation and attempts compared to both cisgender incarcerated individuals and non-incarcerated transgender people (Grant *et al.*, 2011).

130. Denial of gender-affirming care removes one of the few stabilizing forces in their psychological and physiological functioning. For many, access to medical transition—whether hormonal, surgical, or social—is critical to maintaining mental health, emotional regulation, and basic functioning (WPATH SOC-8; Brown 2010).

131. In addition to its prohibition on hormone therapy, SB185 causes further medically and psychologically harmful effects by precluding access to other essential gender-affirming interventions, such as social transition, for incarcerated individuals with gender dysphoria.

132. A robust body of empirical research has shown that access to gender-affirming social transition is associated with improved mental health outcomes, including reduced rates of depression, anxiety, and suicidal behavior (Budge *et al.*, 2013; White Hughto & Reisner, 2016). Conversely, when individuals are denied access to gendered items such as appropriate undergarments, grooming products, or clothing, they are effectively compelled to inhabit a public gender role that conflicts with their affirmed identity. This discordance has well-documented psychological consequences, including increased anxiety, depression, demoralization, and suicidal ideation (Budge *et al.*, 2013; White Hughto & Reisner, 2016; Puckett *et al.*, 2019).

133. Accordingly, based on the assumption that the implementation of SB185 constrains gender expression and mandates gender presentation inconsistent with affirmed identity, including through its restriction of access to social transition items such as bras and underwear, it risks exacerbation of psychological harm. The chronic stress of misgendering, systemic invalidation, and institutional denial of affirming items that is likely to result from SB185's plan will contribute to the phenomenon of minority stress, which has been shown to increase the risk of psychological decompensation, even among individuals previously stable on treatment (Testa *et al.*, 2017).

134. The harm of forced gender incongruence, as the SB185 Enforcement Plan requires, is particularly acute in incarcerated individuals who are receiving

gender-affirming hormone therapy. Hormone therapy induces bodily changes—such as breast development, fat redistribution, voice deepening, and facial hair growth—that increasingly distinguish the body from the person's assigned sex at birth. When such individuals are denied social transition items (e.g., bras for transgender women, male underwear for transgender men), as SB185 will require, the imposed mismatch between their physical appearance and required gender presentation is likely to intensify dysphoria and heightens social vulnerability. This incongruence risks provoking severe psychological distress, internalized shame, and behavioral deterioration.

135. Moreover, for individuals on hormone therapy, congruent gender presentation is not merely expressive—it is integrally therapeutic. Social and medical transition function synergistically to relieve gender dysphoria; thus, when both are withdrawn under SB185, the impact will be not merely additive but compounding, undermining prior progress, intensifying psychological distress, and increasing the risk of self-harm.

136. For example, a transgender woman with breast development who is barred from wearing a bra or feminine clothing may experience increased self-consciousness, intensified dysphoria, and greater risk of harassment or sexualized violence. Denial of these items can result in an ingravescent course (where symptoms gradually increase in severity).

137. For instance, SB185's prohibition on interventions such as permanent hair removal, access to prosthetics (e.g., breast forms, packers) also denies transgender individuals the ability to achieve physical and social congruence—both of which are recognized as critical components of treatment for gender dysphoria. These interventions, while sometimes labeled as cosmetic or non-medical, are in fact endorsed by leading clinical guidelines and supported by empirical data for their ability to alleviate severe gender dysphoria symptoms. (Coleman, E., *et al.*, 2022; James *et al.*, 2016).

138. Moreover, and although nonconsensual discontinuation of hormone therapy never satisfies the standard of care, even when withdrawal is tapered over a few weeks, as SB185 and the State's corresponding policy require, the harm is not necessarily mitigated. The State's 4–8 week tapering protocol does not account for the clinical significance of hormone therapy as a stabilizing treatment. The pace of physical reversal—such as the return of unwanted secondary sex characteristics—and the psychological impact of perceived forced detransition can lead to severe mental health consequences that cannot be treated with psychotherapy alone, particularly in incarcerated settings where access to support is limited, as detailed below.

139. By obstructing access to these and other forms of gender dysphoria treatment without any regard to patient need, SB185 undermines the principle of

individualized care and in ways that will cause severe and foreseeable harm as detailed below.

DEPRESSION AND ANXIETY

140. As noted above, psychotropic drugs are not treatment for gender dysphoria, and will not resolve anxiety or depression that patients experience as a result of being denied adequate gender dysphoria treatment.

141. It is well established in the medical and psychological literature that the denial of medically necessary gender-affirming healthcare can result in significant psychological harm. Among the most common and foreseeable consequences of such treatment denial are anxiety and depression, which stem from the persistence or worsening of gender dysphoria.

142. Numerous studies have documented that access to gender-affirming hormone therapy is associated with reductions in psychological distress, while its absence or withdrawal contributes to increased rates of mood disorders, self-injury, and suicidality. (Bauer *et al.* 2015; Hembree *et al.* 2017; Radix *et al.* 2016).

143. For example, a large U.S. study found that transgender individuals who had access to hormone therapy reported significantly lower levels of depression, anxiety, and suicidal ideation than those who desired but could not access such care (Bauer *et al.*, 2015).

144. Similarly, a review by the Endocrine Society confirmed that gender-affirming hormone therapy has a positive effect on mood and quality of life, and that failure to provide this care increases the risk of psychiatric symptoms (Hembree *et al.*, 2017). In correctional settings, where individuals are already vulnerable to mental health deterioration, the denial of medically indicated hormone treatment exacerbates psychological distress and may lead to serious mental health outcomes, including worsening depression and heightened anxiety (Radix & Deutsch, 2016). This escalation can cause complete psychological decompensation, manifesting as dissociation, paranoia, or even psychosis.

SUICIDE RISK AND PSYCHOLOGICAL DECLINE

145. Untreated or undertreated gender dysphoria is linked with high rates of suicidal ideation and attempts. Research shows that 41% of transgender individuals have attempted suicide, a rate exponentially higher than the general population. *Id.* Denial of care significantly increases this risk. (Bauer *et al.*, 2015).

146. Over time, improperly managed gender dysphoria worsens. Age-related changes in cortisol and DHEA balance can intensify gender dysphoria, making long-term suffering increasingly intolerable. (Ettner 2013; Ettner & Wylie 2013). For those serving lengthy sentences, the cumulative burden of untreated dysphoria leads to:

a. Progressive symptoms of anxiety, depression, and hopelessness;

b. Inability to perform routine daily activities; and/or

c. Extreme social withdrawal and functional impairment. (Dhejne C., *et al.* 2011).

RISK OF SELF-HARM, SELF-SURGERY, AND PHYSICAL INJURY

147. When gender dysphoria treatment is withheld, many incarcerated transgender individuals become so desperate to alleviate their dysphoria that they resort to dangerous self-surgical attempts, such as the removal of their testicles or penis. A 2015 U.S. Transgender Survey found that 12% of transgender people in custody had attempted self-treatment or self-surgery (James, S. E., *et al.* 2016).

148. These attempts often result in:

a. Hemorrhage, sepsis, and infection;

b. Long-term nerve damage or chronic pain; and/or

c. Disfigurement, disability, or death.

149. Incomplete removal or failed attempts can compound psychological trauma and physical suffering, reinforcing the urgency of access to safe, physician-supervised care.

150. Accordingly, the categorical prohibition of medically indicated care by SB185 not only contradicts established standards of care but also creates grave, foreseeable, preventable harms, including destabilization, psychological

decompensation, auto-castration and/or auto-penectomy and increased suicidality, as detailed above.

HORMONE THERAPY TERMINATION UNDER SB185 CARRIES WITH IT ADDITIONAL PSYCHONEUROENDOCRINOLOGICAL RISKS

151. SB185 mandates the tapering and eventual discontinuation of hormone therapy in Georgia prisons, even for patients who have long relied on it for psychological and physiological stability. This forced withdrawal will predictably destabilize patients' mental health, triggering dysregulation and psychological decompensation. From a neuroendocrine perspective, withdrawal of hormone therapy initiates a cascade of dysregulation that can severely destabilize psychological functioning:

a. **Hormonal disequilibrium**: Cessation of testosterone or estrogen disrupts the hypothalamic-pituitary-adrenal (HPA) axis, increases cortisol secretion, and heightens stress sensitivity (Berga, S.L., *et al.* 2001);

b. **Mood destabilization**: Withdrawal often results in emotional dysregulation, irritability, and impaired impulse control—factors that rapidly erode mental stability (Colizzi, M., Costa, R., & Todarello, O. 2014);

c. **Exacerbation of gender dysphoria**: The reappearance or worsening of incongruent physical traits intensifies distress and dysphoria, significantly elevating the risk of suicidality (Turban, J. L., *et al.* 2020; Pompeo, A., *et al.* 2022);

d. **Reactivation of psychiatric symptoms**: In individuals with co-occurring psychiatric disorders such as bipolar disorder, PTSD, or schizoaffective disorder, the loss of hormonal regulation may precipitate recurrence of psychosis or affective episodes. (Mueller, S. C., *et al.* 2017).

152. In my clinical experience, and based on the Endocrine Society (Hembree *et al.*, 2017), WPATH Standards of Care, and the American Psychological Association, the foreseeable risks associated with SB185's forced discontinuation of hormone therapy in transgender individuals with gender dysphoria are as follows.

153. **Testosterone Withdrawal (Transgender Men):**

The discontinuation of exogenous testosterone, as required by SB185, risks a rapid decline in circulating androgen levels, which in turn causes the following significant multisystem effects:

a. **Musculoskeletal Effects:** Decline in lean muscle mass and strength (muscle wasting), decreased bone mineral density, and increased fatigue.

b. **Metabolic Dysregulation:** Altered insulin sensitivity and elevation in fasting glucose levels, which may increase the risk of insulin resistance or exacerbate existing metabolic syndrome.

c. **Neuroendocrine Effects:** Downregulation of androgen receptor activity and dysregulation of the hypothalamic-pituitary-gonadal (HPG) axis,

leading to symptoms such as neuroexcitability, emotional lability, and increased stress responsivity.

d. **Cardiovascular Effects:** Testosterone withdrawal can lead to elevated sympathetic nervous system activity, increasing cardiac reactivity, thereby raising the risk of hypertension and arrhythmias.

e. **Psychological and Neuropsychiatric Effects:** Withdrawal is associated with insomnia, irritability, anhedonia, increased suicidality, and the reactivation or worsening of major depressive disorder.

154. **Estrogen Withdrawal (Transgender Women):**

The removal of estrogen therapy, as SB185 mandates, risks similar destabilization of numerous physiological systems, including:

a. **Vasomotor Instability:** Estrogen withdrawal leads to hot flashes, night sweats, and thermoregulatory dysregulation—symptoms also common in surgical or menopausal estrogen withdrawal.

b. **Mood Dysregulation:** Estrogen modulates serotonin, dopamine, and norepinephrine pathways; withdrawal is associated with significant increases in depression, anxiety, and cognitive slowing.

c. **Cardiometabolic Risk:** Estrogen withdrawal can increase LDL cholesterol, reduce HDL cholesterol, and increase systemic inflammation, all of which contribute to cardiovascular disease risk.

d. **Reappearance of Masculinized Features:** Loss of estrogen's suppressive effect on male secondary sex characteristics results in the return of facial and body hair, unwanted erections, and increased muscle mass.

e. **The Role of Risk Itself as a Mechanism of Harm:** Even prior to the onset of physical symptoms, the anticipation of forced detransition and reemergence of incongruent secondary sex characteristics can trigger acute stress responses and a cascade of mood and anxiety symptoms. This includes hypervigilance, panic, and risk of psychological decompensation. The withdrawal process can destabilize the hormone milieu, particularly in patients with longstanding therapeutic response to hormone treatment.

155. These harms associated with the discontinuation of hormone therapy are particularly severe in Georgia's prison system because hormone therapy has historically been one of the only forms of gender dysphoria treatment made available to incarcerated individuals. In this context, hormone therapy often represents the *sole* gender-affirming medical intervention an individual receives. Withdrawal, therefore, not only causes physiological destabilization and exacerbates dysphoria, but also removes the one affirming intervention that offered psychological relief and gender congruence. This makes the emotional and physical consequences of discontinuation particularly devastating, heightening the risk of self-harm,

suicidality, and psychological decompensation (WPATH SOC-8; Fraser *et al.*, 2010).

156. These effects are not hypothetical—they represent a foreseeable and preventable psychiatric crisis triggered by the involuntary withdrawal of medically necessary care. (American Psychological Association 2021).

ADDITIONAL PHYSIOLOGICAL RISKS FOR POST-SURGICAL INDIVIDUALS

157. For a subset of transgender women who have undergone gender-affirming orchiectomy or other genital surgeries, hormone therapy is also physiologically essential. In these individuals, the removal of gonadal tissue eliminates the body's ability to produce sex hormones. Thus, exogenous hormone replacement plays an essential role for transgender individuals who no longer produce endogenous sex hormones following gonadectomy.

158. Termination of exogenous estrogen in such cases can result in:

a. Impaired immune function due to diminished lymphocyte production. (Giltay & Gooren 2000).

b. Hypertension and hypoglycemia.

c. Electrolyte imbalance.

d. Severe fatigue, depression, and metabolic dysregulation. (Hembree *et al*. 2017).

159. These outcomes are well-documented and medically anticipated consequences of hormone deprivation in individuals who have undergone gonadectomy. *Id.* The denial of hormones to this population creates not only psychological harm but direct, measurable threats to physical health.

160. Just as denial of estrogen to transgender women post-orchiectomy can result in systemic breakdown, so too can the withholding of testosterone in transgender men who have undergone a hysterectomy or oophorectomy lead to profound and irreversible harm. Discontinuation of testosterone in transgender men can result in significant physiological and psychological destabilization.

161. Testosterone plays a key role in mood regulation, metabolic function, and body composition; its withdrawal can lead to fatigue, depressive symptoms, anxiety, weight gain, and dysregulation of lipid and glucose metabolism (Collet *et al.*, 2013; Gagliano-Jucá *et al.*, 2019; Nieschlag *et al.*, 2004). Some studies also indicate changes in immune function following androgen deprivation (Trigunaite *et al.*, 2015). More critically, the reversal of masculinizing effects—such as return of menstruation, breast regrowth, fat redistribution, and other feminizing physical changes—can severely intensify gender dysphoria, leading to psychological decompensation and increased suicide risk (WPATH SOC-8). For incarcerated transgender men, who already experience heightened distress and limited access to

affirming care, the forced withdrawal of testosterone removes one of the few stabilizing interventions available and constitutes a serious health risk.

162. These risks are not theoretical, in my clinical experience. I have evaluated incarcerated transgender people with gender dysphoria who have experienced significant physiological and psychological consequences following the denial or withdrawal of hormone therapy, up to and including cardiac complications.

CONCLUSION

163. Denying or terminating care to incarcerated people with gender dysphoria via Georgia Senate Bill 185 represents a profound departure from established medical science and clinical standards governing the treatment of gender dysphoria—both generally and among incarcerated individuals. By categorically prohibiting medically necessary gender-affirming care—regardless of individual diagnosis, clinical urgency, or institutional context—the law imposes foreseeable, preventable, and life-threatening harms on a uniquely vulnerable population.

164. As detailed in this report, the denial or withdrawal of gender-dysphoria treatment causes not only physiological destabilization, but also significant psychological deterioration, including increased suicidality, psychological decompensation, and documented cases of self-surgical attempts. These harms are compounded in correctional settings, where institutional stress, surveillance, lack of

privacy, and limited mental health resources further undermine the safety and well-being of transgender inmates.

165. Medical organizations across every discipline—from psychiatry to endocrinology to correctional healthcare—have consistently affirmed the necessity of individualized, evidence-based treatment for gender dysphoria, including social transition, hormone therapy, and, where appropriate, surgical intervention. The SOC published by WPATH are clear: gender-affirming care is not elective, cosmetic, or experimental. It is medically necessary.

166. The blanket prohibition of such care denies treatment for a condition that is widely recognized, diagnosable, and eminently treatable. Such a policy not only undermines the health and safety of transgender people in GDC custody, but is in direct opposition to the standards of care universally recognized by the global medical community.

167. By categorically prohibiting medically necessary gender-affirming care, without requiring individualized consideration of the medical needs of incarcerated individuals, in my professional opinion, SB185 endangers a vulnerable population and puts them at risk of severe, preventable harm, including physical injury, psychological suffering, and injury or death from suicide and castration attempts.

168. Accordingly, because forced discontinuation of medically indicated hormone therapy is never clinically appropriate and can cause serious harm, no clinical guidelines recommend the cessation of hormone therapy in patients who meet criteria for gender dysphoria and have no medical contraindications.

169. The physiological impact of hormone withdrawal is multi-systemic, serious, and in many cases, irreversible or extremely high-risk. Thus, the risks of cardiometabolic instability, psychological deterioration, and endocrine disruption that are likely to result from SB185 are not mitigated by supportive counseling and require the continuation—not withdrawal—of medically necessary treatment for gender dysphoria.

170. Thus, from a clinical perspective, the refusal to provide medically necessary gender dysphoria treatment in prisons and the forced discontinuation of care for gender dysphoria under on SB185 is not only contrary to accepted treatment standards, but the consequences—documented across decades of research and clinical experience—will be physically and psychologically devastating for those affected and, in many cases, life-threatening.

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

Date: August 1, 2025

Respectfully submitted,

Randi C. Ettner, Ph.D.

APPENDIX A

RANDI ETTNER, PHD

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
Past Secretary, World Professional Association for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee Curriculum Development, WPATH
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 Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist on women's health issues
Private practitioner
Adjunct Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago, IL
Advisory Council, National Center for Gender Spectrum Health
Global Clinical Practice Network; World Health Organization
Harvard Law School LGBTQ Clinic Leadership Council

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

2017-2025	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
	Consultant: Walgreens; Tawani Enterprises; Starbucks, Rush University Medical Center
	Private practitioner: clinical and forensic practice
2013	Instructor, Prescott College: Gender-A multidimensional approach
	ICD-11 Member of International Working Group
2011	Consultant to Wisconsin Public Schools
2010	President New Health Foundation Worldwide
2000	Instructor, Illinois School of Professional 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

INVITED PRESENTATIONS AND GRAND ROUNDS

Evolution of Transgender Prisoners' Access to Health Care Behind Bars: 25 Years of Expert Witness Experience Using the WPATH SOC (Versions5-8). WPATH 28th Scientific Symposium, Lisbon, Portugal, 2024. Ettner, R. and Brown, G.

Clinical Perspectives and the Experience of Transgender Prisoners Federal Death Penalty Strategy Session, 2023

IGEN POLITICS intergenerational politics podcast; July, 12, 2023 Episode 199; Apple Podcast, Spotify, YouTube

Working with Transgender Clients National Employment Lawyers Association, St. Louis, MO, 2023

Shifting Sands: Challenges in Providing Surgical Care American Society of Reconstructive Microsurgery, Miami, FL 2023

The Standard of Care for Institutionalized Persons WPATH 27th Scientific Symposium, Montreal, Canada 2022

Healthcare for Transgender Prisoners Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

Sexual Function: Expectations and outcomes for patients undergoing gender-affirming surgery. Whitney, N., Ettner, R., Schechter, L. Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

Care of the Older Transgender Patient, Weiss Memorial Hospital, Chicago, IL, 2021

Working with Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Development Initiaves, Vietduc University Hospital, Hanoi, Vietnam, 2020

What Medical Students Need to Know about Transgender Health Care, American Medical Student Association, webinar presentation, 2019

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

Expectations of individuals undergoing gender-confirming surgeries Schechter, L., White, T., Ritz, N., Ettner, R. Buenos Aires, 2018

The mental health professional in the multi-disciplinary team, *pre-operative evaluation and assessment for gender confirmation surgery,* American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating transference and countertransference issues, WPATH Global Education Initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

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, IL, 2017

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

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017

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

Tomboys Revisited: Replication and Implication; Amsterdam, Netherlands, 2016

Orange Isn't the New Black Yet- Care for incarcerated transgender persons, WPATH symposium, Amsterdam, Netherlands, 2016

Can two wrongs make a right? Expanding models of care beyond the divide, Amsterdam, Netherlands, 2016

Foundations in mental health; WPATH Global Education Initiative, Chicago, IL 2015

Role of the mental health professional in legal and policy issues, WPATH Global Education Initiative, Chicago, IL 2015

Healthcare for transgender inmates; WPATH Global Education Initiative, Chicago, IL 2015

Children of transgender parents; WPATH Global Education Initiative; Atlanta, GA, 2016

Transfeminine genital surgery assessment: WPATH Global Education Initiative, Columbia, MO, 2016

Foundations in Mental Health; WPATH Global Education Initiative; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018.

Role of the forensic psychologist in transgender care; WPATH Global Education Initiative, Minneapolis, MN, 2017; Columbus, Ohio, 2017.

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

Gender affirming psychotherapy; Fenway Health Clinic, Boston, 2015

Transgender surgery- Midwestern Association of Plastic Surgeons, Chicago, 2015

Assessment and referrals for surgery-Standards of Care- Fenway Health Clinic, Boston, 2015

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

How do patients choose a surgeon? WPATH Symposium, Bangkok, Thailand 2014

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

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

Understanding transgender- Nielsen Corporation, Chicago, 2013

Grand Rounds: Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011

Care of the aging transgender patient University of California San Francisco, Center for Excellence, 2013

Grand Rounds: *Evidence-based care of transgender patients* Roosevelt-St. Vincent Hospital, New York, 2011

Grand Rounds: *Evidence-based care of transgender patients* Columbia Presbyterian Hospital, Columbia University, New York, 2011

Hypertension: Pathophysiology of a secret. WPATH symposium, Atlanta, GA, 2011

Exploring the Clinical Utility of Transsexual Typologies- Oslo, Norway, 2009

Children of Transsexual Parents-International Association of Sex Researchers, Ottawa, Canada, 2005

Children of Transsexual Parents- Chicago School of Professional Psychology, Chicago, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003

Family and Systems Aggression against Providers, WPATH Symposium, Ghent, Belgium 2003

Children of Transsexual Parents-American Bar Association annual meeting, New York, 2000

Grand Rounds: Gender Incongruence in Adults, St. Francis Hospital, 1999.

Gender Identity, Gender Dysphoria 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

Highland Park Early Child Development Program, Highland Park, IL 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.

Grand Rounds: Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1990

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

Hamadian, A., Whitney, N., Reynolds, A., Stoehr, J., Ettner, R. (2024) Improving access to care and consent for transgender and gender diverse youth in the United States. *Georgian Medical News*, 1(346).

Ettner, R., Schechter, L., & Coleman, E. (Eds.) Principles of Transgender Medicine and Surgery, 3rd edition; Routledge, (under contract).

Coleman, E., Radix, A., Bouman, W., Brown, G., deVries, A.L., Deutsch, M., Ettner, R., et. al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23:sup1S1-S259.

Robles, C., Hamidian, A., Ferragamo, B., Radix, A., De Cuypere, G., Green, J., Ettner, R., Monstrey, S., Schechter, L. Gender affirmation surgery: A collaborative approach between the surgeon and the mental health professional. *Journal of Plastic and Reconstructive Surgery* in press.

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Ettner, R. Etiology of gender dysphoria in Schechter (Ed.) Gender Confirmation Surgery: Principles and Techniques for an Emerging Field. Elsevier, 2017.

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.

Ettner, R., Ettner, F. & White, T. Choosing a surgeon: an exploratory study of factors influencing the selection of a gender affirmation surgeon. *Transgender Health*, 1(1), 2016.

Ettner, R. & Guillamon, A. Theories of the etiology of transgender identity. In Principles of Transgender Medicine and Surgery. Ettner, Monstrey & Coleman (Eds.), 2nd edition; Routledge, June, 2016.

Ettner, R., Monstrey, S, & Coleman, E. (Eds.) Principles of Transgender Medicine and Surgery, 2nd edition; Routledge, June, 2016.

Bockting, W, Coleman, E., Deutsch, M., Guillamon, A., Meyer, I., Meyer, W., Reisner, S., Sevelius, J. & Ettner, R. Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology and Diabetes*, 2016.

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Ettner, R. Surgical treatments for the transgender population in Lesbian, Gay, Bisexual, Transgender, and Intersex Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care. Ehrenfeld & Eckstrand, (Eds.) Springer: MA, 2016.

Ettner, R. Etiopathogenetic hypothesis on transsexualism in Management of Gender Identity Dysphoria: A Multidisciplinary Approach to Transsexualism. Trombetta, Liguori, Bertolotto, (Eds.) Springer: Italy, 2015.

Ettner, R. Care of the elderly transgender patient. *Current Opinion in Endocrinology and Diabetes, 2013, Vo*l. 20(6), 580-584.

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Ettner, R. Psychotherapy in Voice and Communication Therapy for the Transgender/Transsexual Client: A Comprehensive Clinical Guide. Adler, Hirsch, Mordaunt, (Eds.) Plural Press, 2012.

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Monstrey, S. De Cuypere, G. and Ettner, R. Surgery: General principles in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Routledge Press, 2007.

Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium,* 31-32.

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Ettner, R. and White, T. in Transgender Subjectives: A Clinician's Guide Haworth Medical Press, Leli (Ed.) 2004.

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Witten, T., Benestad, L., Berger, L., Ekins, R., Ettner, R., Harima, K. Transgender and Transsexuality. Encyclopeida of Sex and Gender. Springer, Ember, & Ember (Eds.) Stonewall, Scotland, 2004.

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

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

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

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

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

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

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

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

PROFESSIONAL AFFILIATIONS

University of Minnesota Institute for Sexual and Gender Health–Leadership Council

American College of Forensic Psychologists

World Professional Association for Transgender Health

WPATH GEI SOC 8 Certified Member

New Health Foundation Worldwide

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

University of Minnesota, Institute for Sexual and Gender Health; 50 *Distinguished Sex and Gender Revolutionaries* award, 2021

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018

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

Phi Beta Kappa, 1972

Indiana University Women's Honor Society, 1970-1972

Indiana University Honors Program, 1970-1972

Merit Scholarship Recipient, 1970-1972

Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972

Representative, Student Governing Commission, Indiana University, 1970

Sponsor 2nd International Trans Studies Conference

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

MATERIALS CONSIDERED

SCIENTIFIC LITERATURE

American Medical Association (AMA) (2019). *AMA Policies on LGBTQ+ Issues.* https://policysearch.ama-assn.org– AMA policy H-185.950

AMA, *Issue Brief: Health Insurance coverage for gender affirming care of transgender patients* (2019), https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf;

AMA, House of Delegates Resolution 122 (A-08) (2008), https://www.tgender.net/taw/ama_resolutions.pdf.

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Bauer, G. R., et al. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent-driven sampling study in Ontario, Canada. *BMC Public Health*, 15(1), 1–15.

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Berga, S. L., et al. (2001). Neuroendocrine mechanisms in stress-induced anovulation. *Ann NY Acad Sci*, 943(1), 129–138.

Berglund H, Lindström P, Dhejne-Helmy C, Savic I. (2008). Male-to-female transsexuals show sex-atypical hypothalamus activation when smelling odorous steroids. *Cereb Cortex*. 2008 18:1900-8

Bouman, W. P., Schwend, A. S., Motmans, J., Smiley, A., Safer, J. D., Deutsch, M. B., & Winter, S. (2016). Language and trans health. *Int J Trans 17*(1), 1–6.

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OTHER MATERIALS

Email from Gerald Wynne, Centurion Georgia Statewide Medical Director, to Marlah Mardis, GDC Statewide Medical Director, Sallie Barker, GDC Director of Health Services, and Randy Sauls, GDC Assistant Commissioner, related to SB 185 implementation (June 9, 2025).

Centurion, PowerPoint Presentation re Ga. Dep't of Correcs. SB 185 (2025).

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Ga. Dep't of Correcs., Standard Operating Procedure on the Identification, Evaluation, and Treatment of Gender Dysphoria (SOP 508.40) (2023).

Ga. Dep't of Correcs., Standard Operating Procedure on the Management and Treatment of Transgender Offenders (SOP 507.04.68)

Ga. Dep't of Correcs. Standard Operating Procedure 220.09, Classification and Management of Transgender and Intersex Offenders (July 2019).

Ga. Dep't of Correcs. SOP 206.04, Feminine Hygiene Items Issuance (2019).

APPENDIX C

APPENDIX B

	Phenotype	Hemisphere
Transmen [1]		
Cerebral compartments		
Gray matter	Feminine	
White matter	Feminine	
Intracraneal volume	Feminine	
Cerebrospinal fluid	Feminine	
Cortical thickness		
Global	Feminine	Right
Parieto-temporal	Feminine	Right & left
Parietal	Feminine	Right
Subcortical structures		
Putamen	Masculine	Right
White matter microstructure		
Longitudinal superior	Masculine	Right & left
Forceps minor	Masculine	Right
Corticospinal tract	Masculine	Right
	Defeminized	
Transwomen [2]		
Cerebral compartments		
Gray matter	Masculine	
White matter	Masculine	
Intracraneal volume	Masculine	
Cerebrospinal fluid	Masculine	
Cortical thickness		
Global	Feminine	Right
Orbitofrontal	Feminine	Right
Insular	Feminine	Right
Cuneus	Feminine	Right
White matter microstructure		
Longitudinal superior		Right
Fronto-occipital inferior	Demasculinized	
Forceps minor	Masculine	Right
Cingulum	Demasculinized	Right
Corticospinal tract	Demasculinized	Right
	Demasculinized	

[1] Data transformed from Rametti *et al.* (2011b); Zubiarre-Elorza *et al.* (2013)
[2] Data transformed from Rametti *et al.* (2011a); Zubiarre-Elorza *et al.* (2013)