IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.,* Defendants.	Civ. No. _____

DECLARATION OF DR. RANDI C. ETTNER

1. I, Randi C. Ettner, have been retained by counsel for Chelsea E. Manning to prepare this evaluation and declaration in connection with the above-referenced litigation. The purposes of this report are: i) to provide the Court with scientific information about gender dysphoria, the impact of this condition on the health and well-being of individuals who suffer from it, and the standard of care for treatment; and ii) to present the results of my evaluation of Ms. Manning, including my diagnosis and recommended treatment. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

Qualifications and Basis for Opinions

2. In arriving at the opinions and conclusions contained in this report, I have relied on a clinical interview with Ms. Manning, a psychodiagnostic assessment of Ms. Manning, a review of her medical records, my extensive experience diagnosing and treating gender dysphoria, and the body of research, including my own, in this area.

3. I began my work with transsexual patients in 1977, while an intern at Cook County Hospital.

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

5. I am the chief psychologist at the Chicago Gender Center, a position I have held since 2005. During the course of my career, I have evaluated or treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

6. I have published three books, including the medical text entitled *Principles of Transgender Medicine and Surgery* (co-editors Monstrey & Eyler; Routledge, 2007). I have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I have served as a member of the University of Chicago Gender Board, and am a member of the editorial board for the *International Journal of Transgenderism*.

7. I am a member of the Board of Directors of the World Professional Association for Transgender Health (WPATH) (formerly the Harry Benjamin International Gender Dysphoria Association), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People* (7th version), published in 2012. The WPATH-promulgated Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

8. I have lectured throughout North America and Europe on topics related to gender dysphoria.

9. I often give grand rounds presentations on gender dysphoria at medical hospitals.

10. I was deposed as an expert in the following cases over the past four years: *Jane Doe v. Clenchy, et al*., No. CV-09-201 (Me. Super. Ct. 2011); *Kothmann v. Rosario*, No. 13-CV-28-OC22 (D. Fla. 2013).

11. I have been retained as an expert in gender dysphoria in multiple cases involving the treatment of gender dysphoria in prison settings.

12. In one of these cases, *Fields v. Smith*, No. 06-C-112 (E.D. Wisc. 2006), I gave testimony in court and was qualified as an expert.

13. I have appeared as an expert on gender dysphoria on hundreds of television and radio shows throughout the country, and I have been a consultant to news media.

14. My consulting fee is $250 per hour.

15. A true and correct copy of my Curriculum Vitae (CV), which includes all of my publications, is attached hereto as **Exhibit A**.

16. A bibliography of the sources referenced in this declaration is attached as **Exhibit B**.

Gender Dysphoria

17. Gender dysphoria, formerly known as gender identity disorder (GID), is a serious medical condition codified in the International Classification of Diseases (10th revision; World Health Organization) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders–5th edition (DSM-V). The condition is characterized by an incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning as a result. The suffering that arises from this condition has often been

described as "being trapped in the wrong body." "Gender dysphoria" is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition.

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

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

19. Without treatment, individuals with gender dysphoria experience anxiety, depression, suicidality and other attendant mental health issues. (*See*, *e.g.*, Fraser, 2009; Schaefer & Wheeler, 2004; Ettner, 1999; Brown, 2000, DSM-V (2013)). They are also frequently socially isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization that over time proves ravaging to healthy personality development and interpersonal

relationships. A recent survey shows a 41% rate of suicide attempts among transgender people, far above the baseline rates for North America. (Haas *et al.*, 2014).

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

21. Gender dysphoria intensifies over time. The longer an individual goes without treatment, the greater the risk of severe harms to her health. (Ettner & Wylie, 2013; Ettner, 2013).

The Treatment of Gender Dysphoria

22. The standards of care for treating gender dysphoria are set forth in the World Professional Association for Transgender Health's *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (WPATH Standards of Care). The WPATH Standards of Care are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association. (*See* American Medical Association (2008), Resolution 122 (A-08); American Psychiatric Association-DSM-V; American Psychological Association Policy Statement on Transgender, Gender Identity, and Gender Expression Non-discrimination (2009)).

23. The Standards of Care identify the following treatment protocols for treating individuals with gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/ chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

24. 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.

25. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with gender dysphoria.

26. The WPATH Standards of Care specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. In addition to these minimum credentials, clinicians working with patients with gender dysphoria should develop and maintain cultural competence to facilitate their work. This specialized field of medicine is associated with a large amount of literature associated with ongoing improvements and refinements in care.

27. To develop competence in the assessment and treatment of gender dysphoria, clinicians should work under the supervision of mental health professionals with established expertise in this area and pursue self-study. Self-study, however, 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.

28. Treatment plans and decisions developed and made by individuals lacking the needed clinical experience can result in completely inadequate or even dangerous care for patients with gender dysphoria.

29. Psychotherapy or counseling can provide support and help with the many issues that arise in tandem with gender dysphoria. Counseling alone, however, is not a substitute for medical intervention where medical intervention is needed nor is it a precondition for such intervention. 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.

30. For many individuals with gender dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called the "real life experience," are an important part of treatment for the condition. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007).

31. For individuals with persistent, well-documented gender dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. 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. (*See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009)).

32. The goals of hormone therapy for individuals with gender dysphoria are 1) to significantly reduce hormone production associated with the person's birth sex and, thereby, the secondary sex characteristics of the individual's birth sex and 2) to replace circulating sex hormones associated with the person's birth sex with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e., males born with insufficient testosterone or females born with insufficient estrogen). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009)).

33. The therapeutic effects of hormone therapy are twofold: 1) 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 2) 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 a sense of well-being. (*See*, *e.g.*, Cohen-Kettenis & Gooren, 1992).

34. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and well documented in the literature. For example, in one study, researchers investigated 187 transsexual patients who had received hormones and compared them

with a group who did not. Untreated patients showed much higher levels of depression, anxiety, and social distress. (Rametti, *et al*., 2011; *see also* Colizzi, *et al*. 2014; Gorin-Lazard *et al*., 2011).

35. The beneficial physical and psychological effects of hormone therapy are so profound that individuals with gender dysphoria who lack access to medically supervised hormones often resort to procuring and using hormones without medical supervision. (Gooren, 2011).

36. For some individuals with gender dysphoria, relief cannot be achieved without surgical interventions to change primary or secondary sex characteristics, *e.g.* genital or chest reconstruction. The safety and efficacy of such treatments are observed clinically and well documented in the literature. (Pfafflin & Junge, 1998; Smith *et al*., 2005; Jarolim *et al*., 2009). Other individuals experience profound relief from hormone therapy alone and do not require surgical intervention. (WPATH Standards of Care, 2013).

37. Like protocols for the treatment of diabetes or other medical disorders, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the National Commission on Correctional Health Care (NCCHC) recommends treatment in accordance with the WPATH Standards of Care for people in correctional settings. (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (October 18, 2009), http://www.ncchc.org/transgender-health-care-in-correctional-settings).

Evaluation of Chelsea Elizabeth Manning

38. I met with Chelsea Manning at the United States Disciplinary Barracks at Fort Leavenworth, Kansas on August 27, 2014. Prior to the meeting I reviewed Ms. Manning's medical records including: her Rule for Court Martial 706 evaluation; a July 29, 2010 Memorandum for Record signed by Jeffrey Barr, LCDR, USNR; Quantico observation notes from July 30, 2010 to April 15, 2011; and treatment records from Captain Worsely. During our meeting I administered four standardized psychometric indices with high levels of reliability and validity: the Beck Anxiety Inventory, the Beck Depression Inventory, the Traumatic Symptom Inventory, and the Beck Hopelessness Scale. I also conducted a clinical assessment of Ms. Manning's gender dysphoria and treatment needs.

Results of assessment

39. Ms. Manning presents with well-documented, intractable and untreated gender dysphoria. She meets the full criteria for the DSM-V diagnosis of the condition. Her medical records indicate that a diagnosis of gender dysphoria has been confirmed many times since her first diagnosis in 2010. The gender dysphoria is moderate-to-severe based on a review of Ms. Manning's medical records and my clinical assessment.

40. Ms. Manning has presented as female in the past when she was able, and has legally changed her name to reflect her affirmed female gender identity. This has been a crucial, but incomplete part, of her identity consolidation.

41. Ms. Manning experiences symptoms associated with generalized anxiety. The intensity of the symptoms is moderate to severe, and the symptoms are predominately somatic aspects of anxiety. These include feeling hot, heart pounding,

discomfort in abdomen, and face flushing. This cluster of symptoms describes autonomic aspects of anxiety, not subject to voluntary control or cognitive reappraisal.

42. Ms. Manning also reveals affective symptoms of depression—crying, sadness, loss of interest, and suicidal ideation.

43. Ms. Manning scores high on scales measuring the extent of hopelessness. Hopelessness is a psychological construct that underlies a variety of mental health disorders. Hopeless individuals believe that their important goals cannot be attained and that their worst problems will never be solved. (Stotland, 1969). The Beck Hopelessness Scale has utility as an indirect indicator of suicidal risk in individuals who have prior suicide attempts and ideation. Ms. Manning scored an 11 on this instrument. Scores of 9 or more were predictive of eventual suicide, and hopelessness has been repeatedly found to be a better predictor of suicide than depression. (Beck, 1986). A study of 1,969 outpatients who were administered the Beck Hopelessness Scale found that of those who ultimately committed suicide, 93.8% had scores of 9 or higher. Clinicians are advised to monitor patients describing moderate to severe levels of hopelessness for suicidal potential.

44. Hopelessness and depression often overlap with but differ from demoralization. Demoralization is common among prison inmates. It is characterized by the individual's awareness that they have failed to meet their expectations and an inability to cope with the present reality of their incarceration. Ms. Manning shows a relatively robust ability to deal with her external reality, and has adapted to incarceration. Her symptoms arise predominately from her internal experience of gender dysphoria and

the inability to modulate, avoid, or soothe the negative state. This creates a tendency in patients to externalize distress through suicidality, aggression, or self-mutilation.

45. Were Ms. Manning's gender dysphoria to be properly treated all of these symptoms would be attenuated or eliminated.

Treatment Recommendations

46. Based on my evaluation, it is my professional opinion that Ms. Manning's gender dysphoria requires immediate treatment by a qualified provider. My treatment recommendations for her are based on my clinical experience in evaluating and treating gender dysphoria, my knowledge of the literature in the treatment of gender dysphoria, and my assessment of Ms. Manning's particular clinical needs.

47. Because Ms. Manning presents with moderate-to-severe gender dysphoria that has persisted and is associated with clinically significant distress, hormone therapy is necessary and should be initiated immediately.

48. An appropriate hormone protocol for Ms. Manning would consist of estrogens (transdermal or injectable), anti-androgens (e.g. spironolactone 100mg per day), and ongoing monitoring via appropriate laboratory follow-up. All clinical care should be provided by clinicians with training and experience in this specialized area of medicine.

49. In addition, she should be immediately permitted to outwardly express her female gender through grooming standards that permit her to grow her hair and to access cosmetic and grooming items available to female prisoners.

50. The provision of female underwear and sports bras to Ms. Manning in August of 2014 is not, on its own, treatment for gender dysphoria. The purpose of the

real life experience, which is an important part of treatment for Ms. Manning, is to consolidate the individual's gender identity. This requires the patient to outwardly present herself through social signifiers of gender consistent with her gender identity. Because undergarments are not seen by others, they do not allow the patient to communicate her gender to others, which is the essential component of this aspect of treatment. Thus, they are not a part of the real life experience on their own and will not alleviate Ms. Manning's distress or treat her gender dysphoria.

51. It is my opinion that at this time Ms. Manning's treatment needs have not been properly identified by her current providers.

Consequences of Lack of Treatment

52. Given that prisoners with untreated gender dysphoria often perform auto-castration (or attempt to), lack of appropriate health care, particularly for prisoners serving long sentences, places them at extremely high risk.

53. In the case of Ms. Manning, her medical records reflect that the desperation caused by her lack of treatment for gender dysphoria has, on more than one occasion, prompted her to have thoughts of performing self-surgery to remove her testicles. In addition, in 2010, while in Kuwait, she seriously contemplated and made plans to commit suicide. She stated that she felt helpless and hopeless and "gave up."

54. Ms. Manning's hope that she will receive treatment including hormone therapy and the ability to outwardly express her female gender is what sustains her. She is concerned with her treatment needs, above all else, including the appeal of criminal convictions.

55. Given that she has a history of suicidal ideation, a past concrete plan to commit suicide, and recurrent thoughts of auto-castration (self-surgery), Ms. Manning is at extremely high future risk for self-injury or suicide if treatment is withheld.

56. There are no contraindications to the implementation of my recommended treatment plan for Ms. Manning. The potential consequences of denying this treatment, however, are predictable and dire.

Summary of Opinions and Recommendations

57. Gender dysphoria is a serious medical condition that is diagnosed using the criteria set forth in the DSM-V.

58. Withholding medically necessary treatment will cause acute and chronic medical and mental health dangers. Since gender dysphoria tends to intensify over time, every month that goes by without this treatment increases the risk of serious harm.

59. Based on my evaluation of Chelsea Manning, it is my professional opinion that she has persistent gender dysphoria, a serious and pernicious medical condition for which she is not receiving adequate treatment.

60. Ms. Manning's treatment needs are urgent and cannot be met without immediately providing her 1) hormone therapy; and 2) permission to follow female grooming standards (including growing her hair in particular) that permit her to outwardly express her female gender.

61. Continuing to withhold this necessary treatment from Ms. Manning puts her at significant risk of disastrous health consequences that can and should be avoided.

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

Executed on September 18, 2014.

/s/ *Randi C. Ettner*
Randi C. Ettner, Ph.D

Exhibit A

RANDI ETTNER, PHD

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POSITIONS HELD

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

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois Major: Clinical Psychology
BA, 1969-72	Indiana University (cum laude) Bloomington, Indiana Major: psychology, Minor: sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social relation undergraduate summer program in

group dynamics and processes

CLINICAL AND PROFESSIONAL EXPERIENCE

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

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

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

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

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

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

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

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

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

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

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

Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

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

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

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

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

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

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

PUBLICATIONS

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

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

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgendered. 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," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School – Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
Advisory Board, Literature for All of Us
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Board of Directors, Chiaravalle Montessori School
Phi Beta Kappa

AWARDS AND HONORS

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

LICENSE

Clinical Psychologist, State of Illinois, 1980

Exhibit B

Bibliography of Sources Cited in Declaration of Dr. Randi C. Ettner

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