The Honorable Benjamin H. Settle

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMMANDER EMILY SHILLING, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 2:25-cv-00241-BHS **DECLARATION OF DR. RANDI C. ETTNER, Ph.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Randi C. Ettner, Ph.D., declare as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

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

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BACKGROUND AND QUALIFICATIONS

Qualifications and Experience

4. I am a licensed clinical and forensic psychologist with extensive experience working with transgender people and a specialization in the diagnosis, treatment, and management of individuals with gender dysphoria.

5. I received my doctorate in psychology 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/Posttraumatic Stress Disorder (PTSD).

6. I have been working with transgender people and been involved in the treatment of patients with gender dysphoria since 1977. From 2005 to 2016, I was the chief psychologist at the Chicago Gender Center, which specializes in the treatment of individuals with gender dysphoria. Since that time, I have been a member of the medical staff at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital.

7. During the course of my career, I have evaluated, diagnosed, and treated over 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

8. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery* (Ettner, Monstrey & Eyler, 2007) and the second edition (Ettner, Monstrey & Coleman, 2016). I 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.

9. I serve as a member of the editorial boards for the *International Journal of Transgenderism* and *Transgender Health*.

10. I am a co-author of *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, Version 7* ("SOC-7"), published by the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin Gender Dysphoria

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Association) in 2012, and the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("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." The WPATH promulgated *Standards of Care* ("*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.

11. I have lectured throughout North America, South America, Europe, and Asia on topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on gender dysphoria at medical hospitals.

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

13. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my most up-to-date curriculum vitae is attached as **Exhibit A**.

Compensation

14. I am being compensated at the hourly rate of $400.00 for my time spent preparing this report. I will be compensated $550.00 per hour for deposition testimony or trial testimony. I will receive a flat fee of $2,500.00 for out-of-town travel and will be reimbursed for reasonable expenses incurred. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

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Prior Testimony

15. Over the past four years, and prior, I have given expert testimony at trial or by deposition in the following cases: *Cordellioné v. Comm'r, Indiana Dep't of Corr.*, No. 3:23-cv-135-RLY-CSW (S.D. Ind.); *Levy v. Green*, No. 18-1291-TDC (D. Md.); *Zayre-Brown v. North Carolina Dep't of Public Safety,* No. 3:22-cv-00191 (W.D.N.C.); *Roe v. Herrington*, No. 4:20-cv-00484-JAS (D. Ariz.); *Diamond v. Ward*, No. 5:20-cv-00453 (M.D. Ga.); *Stillwell v. Dwenger*, No. 1:21-cv-1452-JRS-MPB (S.D. Ind.); *Letray v. City of Watertown*, No. 5:20-CV-1194 (N.D.N.Y.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Gilbert v. Dell Technologies*, No. 1:19-cv-01938 (JGH) (S.D.N.Y.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); *D.T. v. Christ*, No. CV-20-00484-TUC-JAS (D. Ariz.); *Iglesias v. Connor*, No. 19-cv-0415-RJN (S.D. Ill.); *Monroe v. Jeffreys*, No. 18-15-156-NJR (S.D. Ill.); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D. Tenn.); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa); *Claire v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla.); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa.); *Gore v. Lee*, No. 3:19-CV-00328 (M.D. Tenn.); *Eller v. Prince George's Cnty. Public Sch.*, No. 8:18-cv-03649-TDC (D. Md.); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill.); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass.); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW (D. Idaho).

Bases for Opinions

16. My opinions are based on my education and training, my years of clinical and research experience, including my experiences diagnosing and treating individuals with gender dysphoria, the medical and research literature on transgender health and medical care, and my communications and interactions with other clinicians and leading experts on transgender health and medical care.

17. A bibliography of the materials reviewed in connection with this declaration is attached hereto as **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed

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publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

EXPERT OPINIONS

Sex and Gender Identity

18. At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person's actual sex. However, for transgender people, the sex assigned at birth does not align with the individual's genuine, experienced sex, which sometimes results in the condition of gender dysphoria.

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

20. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectible through karyotyping); gonads and internal reproductive organs (detectible by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); sexual differentiations in brain development and structure (detectible by functional magnetic resonance imaging studies and autopsy); and gender identity.

21. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of their own gender.

22. Gender identity is a deeply felt and core component of human identity. All human beings develop the conviction of belonging to a particular gender, such as male or female, early in life. It is detectible by self-disclosure in adolescents and adults.

23. When there is divergence between anatomy and identity, one's gender identity is paramount and an important determinant of an individual's sex designation. Developmentally, identity is the overarching determinant of the self-system, influencing personality, a sense of

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mastery, relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of satisfaction and quality of life. Psychologist Eric Erickson defined identity as "the single motivating force in life."

24. Like non-transgender people (also known as cisgender people), transgender people do not simply have a "preference" to act or behave consistently with each's gender identity. Every person has a gender identity. It is a firmly established elemental component of the self-system of every human being.

25. The only difference between transgender people and cisgender people is that the latter have gender identities that are consistent with their birth-assigned sex whereas the former do not. A transgender man cannot simply turn off his gender identity like a switch, any more than anyone else could.

26. The WPATH's Standards of Care, Version 8 state: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. … It should be recognized gender diversity is common to all human beings and is not pathological." (Coleman, et al., 2022).

27. The American Psychological Association similarly states: "Whereas diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder." (American Psychological Association, 2021).

28. A growing assemblage of research documents that gender identity has a biological basis and cannot be voluntarily altered. The scientific and medical literature document how gender identity has a strong biological basis and a physiological and biological etiology.

29. 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,

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et al., 2011a; Rametti, et al., 2011b; Luders, et al., 2006; Krujiver, et al., 2000). Interestingly, differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self. Attached as **Exhibit C** is a table depicting the brain areas that differ.

30. It is now believed that gender incongruence evolves as a result of the interaction of the developing brain and sex hormones. For example, one peer-reviewed paper noted that "[s]ex differences in … gender identity … are programmed into our brain during early development" and that "[t]here is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation." (García-Falgueras and Swaab, 2010; *see also* Hare, et al., 2009).

31. Because gender identity has a biological basis, efforts to change an individual's gender identity are therefore both futile and unethical. Past attempts to "cure" transgender individuals by means of psychotherapy, aversion treatments, or electroshock therapy in order to change their gender identity to match their birth-assigned sex have proven ineffective and caused extreme psychological damage. Accordingly, all major associations of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, the American Psychological Association, and WPATH, consider such efforts unethical.

32. For some individuals, the incongruence between gender identity and birth-assigned sex does not create clinically significant distress. However, for others, the incongruence results in gender dysphoria.

33. The ability to live in a manner consistent with one's gender identity is critical to any person's health and wellbeing; this is the case for transgender people and is also a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each transgender person takes to transition are not identical.

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Gender Dysphoria

34. Gender dysphoria is a medical condition associated with the distress that results from the incongruity between various aspects of one's sex. Because gender dysphoria results from an incongruence between gender identity and birth sex, a person with a diagnosis of gender dysphoria is transgender.

35. Gender dysphoria is highly treatable and can be ameliorated or cured through medical treatment.

36. Gender dysphoria is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), published in 2013 and later revised in 2022 ("DSM-5-TR"). It is also codified as "gender incongruence" within the chapter "Conditions related to sexual health" of the *International Classification of Diseases, 11th Revision* ("ICD-11"), the diagnostic and coding compendia for mental health and medical professionals published by the World Health Organization.

37. The adoption in the DSM-5 of "gender dysphoria" as the diagnosis, which replaced the prior diagnosis of "gender identity disorder" contained in the DSM-III and DSM-IV, was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity and was intended to acknowledge that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity disordered. As the American Psychiatric Association explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder." Rather the focus is "on dysphoria as the clinical problem, not identity per se."[1]

38. Similarly, the classification of "gender incongruence" within the ICD-11 "reflects current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health."

[1] The DSM-5 also recognizes the genetic and hormonal contributions to gender incongruence. (DSM-5, at 457).

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39. The medically accepted standards of care for treatment of gender dysphoria are set forth in the WPATH Standards of Care, first published in 1979. (Coleman, et al., 2022). The Endocrine Society has published clinical practice guidelines that are consistent with the WPATH Standards of Care. (Hembree, et al., 2017).

40. These clinical guidelines have been cited and are considered authoritative by all major medical organizations in the United States, including American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, among others.

41. These well-established and widely accepted guidelines recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role, also known as social transition (which involves living in the gender role consistent with one's gender identity)
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring); and
- 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.

42. Gender dysphoria is highly amenable to treatment. With appropriate treatment, individuals with a gender dysphoria diagnosis can be fully cured of all symptoms related to the gender dysphoria diagnosis.

The Process of Gender Transition

43. Gender transition is the process through which a person begins bringing their outer appearance and lived experience into alignment with their core gender. Transition may or may not include medical or legal aspects such as taking hormones, having surgeries, or correcting the

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sex designation on identity documents. Social transition—which often includes correcting one's identity documents to accurately reflect one's sex—is the most important, and sometimes the only, aspect of transition that transgender people undertake. Changes often associated with a social transition include changes in clothing, name, pronouns, and hairstyle.

44. A complete transition is one in which a person attains a sense of lasting personal comfort with their gendered self, thus maximizing overall health, well-being, and personal safety. Social role transition has an enormous impact in the treatment of gender dysphoria.

45. Hormones are often medically indicated for patients with gender dysphoria and are extremely therapeutic. In addition to inducing a sense of wellbeing, owing to the influence of sex steroids on the brain, hormones induce physical changes which attenuate the dysphoria. One or more surgical procedures are medically indicated for some, but by no means all, transgender individuals.

46. The process of gender transition does not "change a woman into a man" or vice versa. Rather, it affirms the authentic gender that an individual person *is*.

CONCLUSION

47. Based on my extensive clinical and research experience, as well as my knowledge of the relevant scientific literature, there is no basis for the premise underlying Executive Order 14183 that having a gender incongruent from one's birth-assigned sex is a "falsehood" that "is not consistent with the humility and selflessness required of a service member." To the contrary, gender identity has a biological basis and gender incongruence is a normal aspect of the human experience.

48. What is more, gender dysphoria is a highly treatable condition that in and of itself should not preclude transgender people from serving in the military.

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I declare under the penalty of perjury that the foregoing is true and correct.

Dated this 11 day of February 2025.

Randi C. Ettner, Ph.D.

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