Expert report of Chester W. Schmidt, Jr., M.D.
Schroer v. Billington

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Material Reviewed for this report

1. Expert Report of Walter O. Bockting, PhD
2. Expert Report of Martha L. Harris, LCSW
3. United States District Court for the District of Columbia-Complaint
4. Unites States District Court for the District of Columbia-Memorandum Order .

Qualifications and Background

1. I am a professor of Psychiatry in the Department of Psychiatry and Behavioral Health Sciences, the Johns Hopkins University School of Medicine.
2. I have been licensed to practice medicine in the state of Maryland since 1960.
3. My education includes a BS from the Johns Hopkins University -1956 and an MD from the Johns Hopkins School of Medicine – 1960.
4. Post-graduate Medical education includes an Internship in Internal Medicine at the Johns Hopkins Hospital-1960, six months of an Internal Medicine residency at Stanford University Hospital -1961, and four years of Psychiatric residency at the Henry Phipps Clinic of the Johns Hopkins Hospital - 1967. I was certified by the American Board of Psychiatry and Neurology (Psychiatry) 1970.
5. I was chair of the Department of Psychiatry of Johns Hopkins Bayview Medical Center from 1972-2006. I am currently Chief Medical Director of Johns Hopkins Health Care and Chair of the Medical Board of Johns Hopkins Bayview Medical Center.
6. I was a co-founder of the Sexual Behavior Consultation Unit of the Johns Hopkins Hospital in 1971, a clinical training and research unit which is still in operation today. The Sexual Behavior

Consultation Unit has continuously been open to the evaluation and treatment of patients with Gender Identity Disorders, Sexual Dysfunctions and Paraphilias. The clinic is a mandatory six month rotation for Psychiatric Residents and a site for Medical student teaching.

7. From 1971 till today, I have personally evaluated an average of a dozen Gender Identity Disorder patients per year. Five (on average) of these patients were evaluated by me, three (on average) were directly presented to me as leader of the case conferences, and I participated in the conferencing of an average of four a year in the clinic. These patients include children, young adolescents, young adults and middle aged adults. I have not treated or managed cases of Gender Identity Disorder since the mid 1980s. As indicated above, my clinical role is as an evaluator of new cases.

8. I have participated in the publication of several peer reviewed journal articles about Gender Identity Disorder and related topics. Publication has not been my focus, but clinical and teaching activities involving Gender Identity Disorder has been during the last 35 years.

9. Gender Identity Disorder is currently classified as a mental disorder and as such is one of many disorders with which a psychiatrist must be familiar. Gender Identity Disorder patients are heterogeneous with regard to their presentation, life stories, personalities, co-morbid psychiatric conditions, co-morbid medical conditions, current life situation, network of relationships, personal assets and liabilities and motivations. I have been clinically active for 40 years with broad experience in inpatient and outpatient settings, evaluating and treating the seriously mentally ill and those with sexual disorders. This clinical experience is the context for evaluating the complex, heterogeneous condition we currently diagnose as Gender Identity Disorder.

Report A

1. Sex (gonadal assignment at birth) refers to the biologic status of a fetus or newborn with regard to their chromosomal configuration of xx genes (female) and xy genes (male). (1)
2. Sexual identity refers to the subjective sense of the individual as to whether they think of

themselves as a male or female. (1, 2)

2a. Gender identity is similar to sexual identity.

2b. Gender role refers to the behaviors expected of a male or female within a given culture.

3. The term sex is not synonymous with sexual identity. Sex is a biologic reality (xx or xy) whereas sexual identity is an acquired, internal, subjective construct about whether an individual considers him/herself to be a male, female or ambivalent.

For most individuals, biologic sex and sexual identity are consistent and aligned. (2) Individuals born with various intersexed conditions (caused by genetic errors) are usually assigned as males or females based on the combination of the genetic set with which the individual was born, fetal exposure to testosterone or not, and the ability to surgically construct appropriate external genitalia. Recent follow up studies have revealed 50% of the children born with xy sex and with forms of intersexed conditions raised as girls reassign themselves as boys/males during adolescence or early adulthood. The implication: this field of study is by no means settled. (3)

Individuals who declare themselves dissatisfied with their sexual (gender) identity and who take steps to live in the cross gender role are normal xx females or xy males with normal external and internal genitalia. If they take cross gender hormones and undergo any or all of the currently available sex reassignment surgeries, the do not change the biologic sex. They do change their sexual identity. The dissatisfaction with sexual identity can take place in childhood, adolescence or adulthood.

4. Gender Identity Disorders were introduced to American psychiatry in 1980 when the

diagnosis was first listed in The American Psychiatric Association's Diagnostic and Statistical Manual III. (2) The diagnosis, 'Transexualism' was also introduced to the International Classification of Diseases-9. The introduction of Gender Identity Disorder in DSMIII was based on a consensus of experts and a position paper written by Richard Green, M.D. The current criteria in DSMIV-R for Adolescents and Adults are: (2)

Criterion A. There must be evidence of a strong and persistent cross gender identification, which is the desire to be, or the insistance that one is, of the other sex.

Criterion B. The cross gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of the sex.

Criterion C. The diagnosis is not made if the individual has a concurrent physical intersexed condition (e., partial androgen insensitivity syndrome or congenital adrenal hyperplasia).

Criterion D. To make the diagnosis there must be evidence of clinically significant distress or impairment of social, occupational, or other important areas of functioning.

5. Gender Identity Disorder is related to one's sex only by virtue of the fact that individuals who are diagnosed with Gender Identity Disorder wish to adopt the opposite sexual identity and adopting the opposite sexual role does not change one's biologic sex. (2)
6. The science supporting the existence of Gender Identity Disorder s a bona fide psychopathologic disorder is limited and based on case studies. The etiology of the disorder is not known. (4) Researchers are split into many camps; some believe there will

ultimately be discovered genetic, hormonal, neurophysiologic causes of Gender Identity Disorder. Others believe there are multiple psychologic factors, child rearing practices and/or sexually motivating factors at play in the development of Gender Identity Disorder. (4)

7. As of today there is no scientific evidence supporting a presumed etiology of Gender Identity Disorder. (4)
8. There are no known pathologic, neuropathologic, psychopathologic, pathophysiologic, genetic or congenital causes of Gender Identity Disorder. (4)
9. Gender Identity Disorder and the term sex are not synonymous. Sex is a biologic reality, xx or xy. Gender Identity Disorder is the term for a diagnostic category listed in DSMIV-R. (2)
10. Sex reassignment surgeries do not change the chromosomal sex of a person who undergoes those surgeries. The surgeries are plastic surgery procedures that alter the morphology of the individual's body.
11. Intersexed conditions are the result of genetic abnormalities that result in missing or ambiguous internal and external genitalia and/or in partial expression of sexual phenotype ordinarily dictated by an xx or xy chromosomal configuration. (3)
12. Intersexed conditions are an exclusionary diagnosis for Gender Identity Disorder. That is, individuals with intersexed conditions cannot be diagnosed as having Gender Identity Disorder. (3) Also see Answer 3.

In his conclusion Judge Robertson states, "There are facts that Schroer could prove which would support her claim that the Library refused to hire her solely because of her sexual identity, and in so doing, the Library discriminated against her, 'because of sex.'"

Judge Robertson appears to equate sex with sexual identity. If the legal issue in this case rests upon sex as the defining point of whether there has been discrimination, equating sex to sexual identity causes an error because sex and sexual identity are not the same as discussed in answers to questions 1, 2, 3, 9 and 10. Schroer has chosen to live in the female gender role but Schroer continues to have an XY chromosomal configuration which identifies Schroer as a genetic male. Most individuals who choose to live in the cross-gender role would not dispute this genetic reality.

References

1. Money, J. Eberhardt, A.A., Man and Woman, Boy and Girl. The Johns Hopkins Press, 1972, Baltimore, Maryland.
2. Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. Text Revision, American Psychiatric Association 2000, Washington, D.C.
3. Reiner, W.G., Gearhardt, J.P., Discordant Sexual Identity in some Genetic males with Cloacal Exstrophy Assigned to Female Sex at Birth, NEJ Med. Jan 2004, Vol. 350, No. 4 pp 333-340.
4. Zucker, K.J., Bradley, S. J. Gender Identity Disorder and Psychosexual Problems in Children and Adolescent. 1995 Guilford Press, New York, NY.

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