UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

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DIANE J. SCHROER, :

Plaintiff, :

v. : CA No. 06-763

JAMES H. BILLINGTON, :

Defendant. :

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Baltimore, Maryland

Wednesday February 21, 2007

Deposition of CHESTER SCHMIDT, M.D., a witness herein, called for examination by counsel for Defendant in the above-entitled matter, pursuant to notice, the witness being duly sworn by BRACHA GOLDBERGER, a Notary Public in and for the State of Maryland, taken at the offices of the United States Attorney for the District of Maryland, 36 South Charles Street, 4th Floor, Baltimore, Maryland, 21201, at 9:29 a.m., Wednesday, February 21, 2007, and the proceedings being taken down by Stenotype by BRACHA GOLDBERGER and transcribed under her direction.

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down. Okay?
A Yes.
Q Okay. It's important for you to answer out loud, since the court reporter cannot record a nod of the head or other gestures. Okay?
A Yes.
Q If you do not understand a question, will you ask me to repeat it or rephrase it?
A Yes.
Q And if you do answer a question, I will assume that you understood the question. Okay?
A Yes.
Q And I will take breaks throughout the day. But if you need a break, you should just let me know. And I'll try to find a place where we can take a break in the questioning, for us to take a pause.
Okay?
A Thank you. Yes.
Q Are you feeling well today?
A Yes.
Q Are you taking any medications today,

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that would prevent you from being able to give complete and accurate testimony this morning?
A No.
Q Okay. Is there any other reason why you would not be able to give complete and accurate testimony today?
A No.
Q Okay. Before we begin, I just want to layout a few terms that I will be using, to make sure that we are on the same page. And, throughout the deposition, I'm likely to refer to a document known as the DSM.
Are you familiar with the DSM?
A Yes. I am.
Q What is it?
A It is the diagnostic and statistical manual of the American Psychiatric Association.
Q Okay. And I will be referring, to the extent that we are referring to, to the most recent edition, which is the fourth edition, revised, which was published in 2000.
Okay?

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A Yes.
Q Part of what we are going to be talking about, today, is what is meant by transsexuality or individuals who are transgender.
What do you understand the term transsexual to mean?
A Transsexuals are individuals who wish to live in the cross gender role.
Q Okay. Anything else?
A Well, there's a lot. But I don't know what you mean by is there anything else.
Q Okay. With respect to the term transgender, do you understand that to mean something different than a transsexual?
A Transgender is a lay term. Transsexual was the official diagnostic term until it was changed, I think, in DSM-IIIR, to Gender Identity Disorder. But transsexual is also, I believe, the official term of the ICD-9 or ICD-10.
So, transgender is a lay term that could mean a lot to a lot of different people. Transsexual was the original diagnostic term.

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Q Okay. That's helpful. And I will, for the most part, attempt to use the proper clinical term, transsexual. If I slip into transgender, or I have created any confusion, by using one term versus the other, please, let me know. Because I want to make sure that my questions are clear, so that we can have a clear dialogue.
Okay?
A Yes.
Q Okay. When did you first learn about this case?
A I'm not sure. Maybe something like six months ago.
Q Okay. And how did you learn about it?
A I got a call from Ms. Douds.
Q And did Ms. Douds seek to retain you, as an expert, in this case?
A Well, eventually. But I don't believe the decision was made right away.
Q Okay. And did you have discussions, with Ms. Douds, about your ability to serve as an expert, potentially, in this case?

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you -- is the list of questions that were posed to me, by Ms. Douds and Ms. Russell. And it was just a review, going one by one, through those questions. And reviewing with them what my response to those questions was going to be, when I got around to doing the final report.
Q And when was that conversation, roughly?
A I don't remember.
Q Was it prior to your completing your report?
A Yes.
Q Okay.
A Yes.
Q And with respect to the second conversation, can you describe to me, roughly, when that conversation was?
A Yes. I think I told you it was the 16th.
Q Okay.
A Right.
Q And, please, tell me about that

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conversation and --
MS. RUSSELL: I'm going to object on relevance grounds. But you can still answer.
BY MS. McGOWAN:
A That conversation dealt, principally, with preparing me for today, just telling me about you and what to expect. What was likely to be covered, what the time frame was going to be, where we were going to meet.
And, once again, going back over the list, and making sure they understood what my terms were, the terminology was, and making sure that they understood the full extent of my answer to those questions, and as expressed, mainly, in the report itself.
Q And with respect to what was likely to be covered today, what did you discuss?
A They said that you would be extremely detailed, and that we would use probably the entire six hours, and that you would ask the same questions over and over again, many times.
Q Anything else?

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A No. That you were a nice person.
Q Well, that's nice to hear. And with respect to anything else that you discussed in that conversation, with Ms. Russell, what can you tell me?
A As I said, I think if my remembrance is -- it was pretty much a review, once again, of the questions that they had posed to me.
Q Okay.
A And to see if I had any modifications or significant changes, or -- which I didn't.
Q Okay. And with respect to the first conversation, just so that I don't -- we don't have to group back to it -- was there anything else, about that first conversation with Ms. Russell, that you discussed that we haven't --
A Not that I remember.
Q -- covered?
A No. Not that I can remember.
Q Okay. So, rather than beat about the bush, I would like to just dive in to your report.

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MS. McGOWAN: I realized, Beverly, that I was slightly off in our numbering from the exhibits for yesterday. So, I will start with the number thirty-four, which leaves two phases for the two documents that we have today, and then we'll keep us going.
So, mark this number.
(Ms. McGowan hands copies of exhibit 34 to all counsel.)
(Exhibit Number 34 was marked for identification.)
BY MS. McGOWAN:
Q And I'm showing you a document that we have marked as exhibit number thirty-four. And it is a printout of an e-mail attachment, that was sent to me by Ms. Russell back in November 22nd, as a copy of your expert report in this case.
Do you recognize this document?
A Yes.
Q Okay. And is this your report?

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A Excuse me. The dictionary, my knowledge of the field of sexology, in that just years of usage of the term, it refers to the biologic status of maleness and femaleness, of being male or being female.

I think it's a term that is used by my colleagues in medicine. And, in my opinion, I believe that most physicians, that would be asked that term, would give an answer very similar to mine.

Q Okay. Are you aware of any colleagues, who use the term sex to mean something different than how you use it?

A I don't know that they use the term sex -- use the term sex, itself, differently. What they -- I think what has evolved, since the sixties, is that a number of associated terms have been developed, that deal with social constructs, associated with the biologic reality of male and female as expressed by the chromosomes of the genes.

But those are social constructs not

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biologic constructs.

Q Other than what you have laid out as the dictionary, your knowledge of the field of sexology, and your years of usage of the term, is there any other basis for your opinion about the meaning of the term sex?

A I don't think so.

Q Okay. Do you rely -- in your report, you actually -- it appears as though you cite a 1972 work by John Money.

Do you rely on Dr. Money's work as part of your opinion, regarding the meaning of sex?

A I don't think -- I think I rely on Money more with regard to these other social constructs, such as gender identity, sexual identity, gender role --

Q And --

A -- as differentiated from the -- from biologic sex.

Q And so, on page three of your report, where, under the statement my answers are as follows, and then there is number one, at the end

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of the sentence there, that says sex and then, in parenthesis, gonadal assignment at birth, refers to the biologic status of a fetus or newborn with regard to their chromosomal configuration of XX genes, in parenthesis female, and XY genes, in parenthesis male.

At the end of that sentence, there is a number one in parenthesis, at the end. What does that number one in parenthesis signify?

A I'm sorry, where are you?

Q Sure. On page three, answer number one.

A Page three. Okay.

Q Right there.

A Good.

Q And at the end of that sentence, there is a number one in parenthesis. At the end.

A Um-hum.

Q What does that one in parenthesis, at the end of that sentence, signify?

A That I took from -- that I did take from John's work.

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Q Okay.

A From his 1972 book.

Q And by John, you are referring to John Money?

A To John Money. Right. Yes.

Q Okay. And so, other than your reference there to John Money, and the dictionary, your knowledge of the field of sexology, and your familiarity with the usage of the term, are there any other bases for your answer number one?

A None other than I have already stated.

Q Okay. Are you familiar with the supplemental report of Dr. Walter Bockting in this case?

A Yes. I am.

Q And did you review it?

A Yes.

Q Okay. Dr. Bockting, in that report -- and if you have a copy of the report -- actually, I'll just pull one out and we can mark it as an exhibit.

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environment, which, in the case of the male fetus, is -- includes testosterone. That is not the case with females.

And that is all -- that is all driven by the -- essentially by the Y chromosome, which is responsible for the genes -- which is responsible for the change in the genital ridge, which eventually produces the testosterone, which eventually produces the male brain.

Q With respect to that last sentence, just so that I'm clear, is it your view that the male brain produces testosterone, or that testosterone produces a male brain, or neither? Please, tell me, just so that I can understand what you meant.

A Well, you know, we are oversimplifying things here. And so, it would be the later. The testosterone environment, in fetal life, is what will produce the male brain.

Q Are you aware of others in the field, who share Dr. Bockting's and Dr. Money's view, that all of the factors listed in Dr. Bockting's

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report, including sex of assignment and rearing and gender identity and role, are part of a person's sex?

MS. RUSSELL: I'm going to object to the extent that it misrepresents Dr. Money's research and conclusions. But you can go ahead and answer.

BY MS. McGOWAN:

A It's difficult to answer that question, because you are making an assumption. Or it sounds like you are making the assumption that the others don't do what I do. And that is differentiate the term sex, in a narrowly defined way, as a biologic issue. But very much related, to that biologic issue, are these other social constructs.

And I don't know that the, quote, others, if pressed, would not parse it out that way. I certainly know there are lots of experts, including myself, who have -- who understand the significance of these other concepts, such as gender identity and gender role.

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But to say that they are an intrinsic part of the diag -- intrinsic part of the definition of sex, per se, I don't know that the others, if pressed, would not make the same parsing that I am making.

Q Okay. And I'm trying to be precise for that exact reason, and ask you whether or not you know of anyone, who does use the term sex to include the concepts of sex of assignment and rearing or gender identity and role?

A Well, I think Dr. Bockting does. And my assumption is that the philosophic and scientific positions, that he and his colleagues take, on the -- you know, who are part of what was previously the Benjamin Society -- the Benjamin Association -- would probably ascribe to a less focused -- a less focused definition of the term sex.

Q Okay. And with respect to these concepts, that you are excluding from your meaning of sex, I just want to go through each one of them.

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Why do you think that --

MS. RUSSELL: I'm going to object to the form of the question. But you can go ahead.

MS. McGOWAN: I'll see if I can start again.

BY MS. McGOWAN:

Q So, there were four items I had originally described in those two items. But you broke them out properly as four items on the list, laid out in Dr. Bockting's report, as items that you would exclude from the term sex. And I just want to go through each one, and ask you why that is.

And so, with respect to sex of assignment, why do you think sex of assignment is not part of sex?

A Because it is not a biologic -- it is not a biologic -- it's not part of the biology. The assignment is a human function that is imposed on that child, at the point of birth or sometime after the point of birth, by individuals surrounding the person. It's not a biologic

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aware of any such condition.
Q And similarly, with respect to the other elements -- the other biological elements of fetal hormonal sex, internal morphologic sex, or external morphologic sex, or hypothalamic sex, are you familiar with any cases in which any of those biologic factors have one sex, whereas the chromosomes would indicate a different sex?
A Oh, yes. There are definitely intersex conditions, in which there are -- where, for example, you have incomplete or complete non tissue response to testosterone. So that, you can have an XY male producing -- a fetus producing testosterone. All right?
And because the end process, in the tissues, there is a blockage of the acceptance of the testosterone, in the end organs, you end up with female genitalia and XY -- with an XY configuration.
So -- and there are all kinds of variations on that theme. So that, there are genetic errors that take place, that result in --

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in which there certainly -- there can be external and internal morphologic differences than what should be -- than what should happen as a result of the actual chromosomal configuration.
So, the genes don't get properly expressed.
Q Okay. And how does that play out with respect to hypothalamic sex? Can you have a female brain but XY chromosomes?
A I'm not aware of a specific condition. But, theoretically, you could. That is, if the receptive sites in the brain, that would normally respond to the presence of testosterone in utero, or as a fetus, then you could end up, theoretically, with a female brain having been exposed to a normal testosterone environment as a fetus in utero.
Q In his report, in paragraph three, Dr. Bockting talks about the sex of assignment. And, specifically, he says that:
Sex is typically assigned at birth on the basis of the appearance of the external

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genitalia, rather than on chromosomal configuration.
Do you agree with that statement?
A Sure.
Q And then he goes on to say:
Only in cases of children born with ambiguous genitalia, additional aspects of sex, eg: internal genitalia, chromosomal sex, hormonal sex, are assessed and considered in the decision -- I'm sorry -- are considered in the decision as to what the best sex of assignment is.
Do you agree with that statement?
A Yes. I do.
Q And then Dr. Bockting says, going on in that paragraph:
In making the decision about the best sex of assignment, the most important factor is the question of what gender identity a child is most likely to develop.
Do you agree with that statement?
A I don't -- you just said it differently

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than is here.
Q Sure.
A In this decision, the most likely outcome of the child's gender identity development is the most important factor.
Q Right.
A The goal is for the sex decided at birth to be congruent with future gender identity of the child.
Q And do you agree with that statement?
A It's a complicated statement. I agree with the goal is for the sex assigned at birth to be congruent with the future identity of the child. I certainly agree with that.
I don't know what the first part is. I don't know what it means. In this decision, the most likely outcome of the child's gender identity development is the most important factor. I don't get the relation -- I don't get the -- I don't get the logical connection, between the previous statements and the last statement.

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subjective sense?
A It's internal to the individual. It's what I know about myself.
Q Anything else with respect to your use of subjective sense?
A No.
Q Okay.
A I think that's pretty much it.
Q And in addition to the experts that you identified, as far as those upon whose work you rely or with whom you agree, with respect to your opinion about what is sexual identity, are there any other bases for your opinion?
A No. I think it's expert -- it's pretty much expert testimony, if you will -- not expert testimony. It's expert opinion that that has come to be the definition of the term gender identity or sexual identity.
Q And I will pull, at this point, the original report of Dr. Bockting, so that you will have all of that --
A Okay.

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Q -- those materials in front of you as well.
MS. McGOWAN: Which we will mark as number thirty-six.
(Exhibit Number 36 was marked for identification.)
BY MS. McGOWAN:
Q And included, in exhibit thirty-six, is the expert report of Walter Bockting dated September 15th, as well as the three exhibits that he attached to his report. Exhibit one being his CV. Exhibit two being a provision, from the DSM IV, regarding Gender Identity Disorder. And then, the third is the Harry Benjamin International Gender Dysphoria Association's standards of care.
A Right.
Q So, that is all included in this document.
A Is that the 2001 standards?
Q Yes. They are.

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A Okay.
Q So, certainly, feel free to refer to that report, if that's helpful, in the course of these questions. In his report, both his opening report and his supplemental report, Dr. Bockting uses the term sexual identity to include gender identity and other factors.
Do you have any disagreement with how Dr. Bockting talks about sexual identity?
A Could we --
Q Sure.
A Could you point me to the --
Q Yes.
A -- page?
Q Certainly. Well, actually, I can point you -- the supplemental report probably has it in a place that is easier to -- on the second page of Dr. Bockting's supplemental report.
A Yes.
Q Paragraph four, he talks about how he is using the term sexual identity in the course of his report. And I wanted to see if there was

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any disagreement, between you and he, about his use of the term.
A So, if I am understanding your question, you are referring to his -- this statement; in my definition, sexual identity has at least four components; sex assigned at birth, gender identity, social sex role, and sexual orientation.
Q Right.
A That is what you are referring to?
Q Right.
A Okay.
Q And so, just so that I'm clear, how does your use of the term sexual identity differ from Dr. Bockting's use of sexual identity as he has laid it out here?
A I would not include sex assigned at birth, social sexual role, and certainly not sexual orientation as a component of sexual identity, which, as I pointed out, is synonymous with gender identity for my purposes in today's deposition.

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answering the question whether the term sex is synonymous with sexual identity.
Were you opining about whether or not those terms are synonymous in fields other than medicine and psychiatry?
A I wasn't thinking specifically of that. But if you are asking the questions, I think that, if you want to include psychology, I would include psychology, and say I don't believe -- I would believe that psychologists, who are interested in this particular aspect of human behavior and the human existence, would make the same differentiation I'm making. And that sex is one thing, is a biologic reality. And sexual identity, slash, gender identity is a social construct.
Q And do you have -- well, actually, before I move on, other than the fields of medicine, psychiatry, and to the extent you are opining, as well, about whether or not these terms are synonymous or not, in the field of psychology, do you have expertise with respect to

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whether or not these terms are synonymous in other any other field, for purposes of your report?
MS. RUSSELL: I'll object to the form of the question. But you can answer.
BY MS. McGOWAN:
A We have social workers. We have mental health counselors. We have nurses. And my experience over the years, with these other fields as well, these are the professions who are involved in the care of the patients, about which we are talking, would also make the same -- also make the same definition or discriminations.
Q Okay. Outside of the field of mental health, are you opining, in your report or here today, about whether or not the term sex and sexual identity are synonymous?
A Are not synonymous? I would say in medicine, in general, that those terms would be differentiated by -- you know, by those physicians who do any thinking about this.
Q Do you have an opinion about whether

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the term gender role is synonymous with the term sex, with respect to medicine in general?
A It would be the same. Pretty much the same answer for those physicians who do any thinking about this, and have taken the time to make these differentiations between sex, gender identity, gender role. I believe that they also would make the same discrimination.
Q Okay. At page six of your report --
(Discussion off the record.)
BY MS. McGOWAN:
Q We are on page six of your report. And you have a statement there. It's sort of the last paragraph on that page. You comment that:
Judge Robertson, quote, appears to equate sex with sexual identity.
And then, in the next sentence, you state that, in your view, that is erroneous.
Do you have any expertise with respect to whether the term sex includes or encompasses the idea of sexual identity as a legal matter?
A No.

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Q And if I told you that the Supreme Court has ruled that, as a legal matter, the term sex includes gender role, would that change your view about whether the term sex includes sexual identity or gender identity as a legal matter?
MS. RUSSELL: I'm going to object to the form of the question.
BY MS. McGOWAN:
A Is that a hypothetical?
Q Well, I will represent to you that the Supreme Court -- and you could argue about this -- but that the Supreme Court has ruled that sex includes gender role as part of its meaning.
And so, I'm asking whether or not that changes your view about whether or not Judge Robertson is incorrect to equate sex with sexual identity?
A If that's the case, then I think, from a legal -- you know, not being a lawyer -- but from a legal perspective, that might support Judge Robertson's position. But in terms of as a psychiatrist, scientist, clinician, it would not

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it demonstrates is that sometimes it works and sometimes it doesn't. I think that's the message that I take home in terms of, I think, what we are trying to work on today.

Q Okay. And how does this study support your conclusions in your report, if at all?

A I think it's not so much a conclusion as an observation, from the literature, what we can observe is that sometimes -- sometimes this reassignment works and sometimes it doesn't.

What it does do is it opens up a very important and interesting set of research questions.

Q And how, if at all, does Dr. Reiner's study support the conclusion that sex does not equal, or is not the same as sexual or gender identity?

A Well, in that realm, what it demonstrates is that the -- is that there can be this remarkable disassociation between the biologic sex. In this instance, it's the males, XY males born with this non closure of the

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midline, so that their bladder is open. Normal male brain.

And, in fifty percent of them, there is, you know, about fifty percent of the cases, they are successfully raised as females because of the social process, that is a decision at the point of birth or shortly thereafter, that is complete disassociation between the gender that is assigned and what they are raised in, as compared to what their biologic sex is.

So, it's an experiment in nature, if you will, that demonstrates that you can take a -- you can, you know, under certain circumstances, you can take an XY male and raise them as a female successfully, whatever that -- you know, whatever successful means within the context of the paper.

Now, that has also been demonstrated by Claude Mignon, one of John Money's associates. He's actually the guy that John got started with. And Mignon published an even larger series that demonstrates the same thing. That you can take

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XY intersex boys, who have a variety of intersex conditions, reassign them at birth, give them hormones, do the surgeries. And a significant portion of them in his group, which is fifty -- I think, almost fifty cases over twenty years -- and, again, you can override the biology.

And through the process of gender identification, which is a social construct, and a social process, come out at the end with a group of women. You know, you have somebody functioning as a female.

Now, there has been no change in the biology. What you have changed -- what you have changed is the gender identification, which is directly related to the social process of how the child was raised. And what people around the child have told the child; you are a girl, you are a girl, you are a girl, you are a girl.

So, we have two studies. You know, both around the same time; 2000, 2003, something like that, that provide these observations.

Q And what is the significance, in your

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view, of the fact that roughly half of the subjects, in Dr. Reiner's study, had a female gender identity not withstanding their male chromosomes?

A Well, you can't make that statement; not withstanding their chromosomes.

Q Okay.

A The chromosomes are what they are.

Q Right.

A In this instance, in Reiner's study, that is what we are referencing?

Q Right.

A They are XY.

Q Right. And so that, XY is traditionally the male --

A That's correct.

Q -- chromosome marker. Right?

A Yes.

Q And my understanding -- and, please, correct me if I'm wrong -- is that children with XY chromosomes were raised as girls?

A Correct.

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of their biologic sex?
A No.
Q Okay. I'm going to say that my own question was vague, because I'm not exactly sure, sort of, if I understand your answer. So, in your view, are an individual's hormones part of their biologic sex?
A Sure.
Q Is an individual's internal genitalia part of their biologic sex?
A Yes.
Q Is an individual's external genitalia part of their biologic sex?
A Yes.
Q And so, when you say biologic sex, are you talking about -- well, actually, let me take that back. When you talk about an individual being unable to change their biologic sex --
A Right.
Q -- in that context, do you mean biologic sex only to mean chromosomes?
A Of course. I mean these other things

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are not going to happen unless you have these chromosomal configurations. That is the basis of it all. So, you can change the exterior, but you are still an XX or an XY. That doesn't change.
Q Okay.
A And that's the -- in my opinion, that is -- as we have gone over it many times so far, that is the core part of the definition of what sex is.
Q But it is possible for transgender individuals to undergo treatment that would change their hormonal sex. Isn't that right?
MS. RUSSELL: Objection to the form of the question.
BY MS. McGOWAN:
A Well, sure. Yeah. If you take cross gender hormones, you change the balances of estrogen, testosterone, FSH, LH, you know, all of the things. All of the related hormones. Right.
Q And, similarly, an individual, who undergoes sex reassignment, can change the aspect of their biologic sex that is encompassing their

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internal genitalia. Correct?
A They can change the external and internal. They can change the internal and external genitalia. Yes. That are the consequences of their biologic sex.
Q And so, the -- am I correct, the only aspect of an individual's biologic sex, that cannot be changed through gender reassignment surgeries and treatments, is chromosomes. Correct?
A And the brain.
Q Okay. What is the sex of an individual who has female hormones, female internal genitalia, female external genitalia, but XY chromosomes? What is that individual's sex in your view?
MS. RUSSELL: Objection. Vague.
BY MS. McGOWAN:
A Run that by me again.
Q Sure. An individual, who has XY chromosomes, but has female hormones, internal genitalia, and external genitalia, what is that

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person's sex in your view?
MS. RUSSELL: Same objection.
BY MS. McGOWAN:
A In my opinion, they would be biologic males.
Q And that view is because, for purposes of biologic, you are talking about chromosomes exclusively. Correct?
A The chromosomes and the genes. And I think you are talking about the androgen insensitivity syndrome, in which the receptors don't respond to the presence of the testosterone.
Q Okay. Are there other scholars, in the field of gender identity, who also believe that biologic sex means chromosomes, but not hormones and genitalia?
A Yes. I think we have gone over that.
Q Okay. And who are they? Who are the individual that share your view, that biologic sex is chromosomes but not hormones and genitalia?

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used?
A Yes.
Q Tell me, what do you mean by that?
A There is no phase of this field, with regard to gender identity, that has any scientific basis. There is no known etiology of the disorder. There has never been -- there have never been any kind of studies that provide any controls, with regards to the use of any of the treatments.
There certainly have been no -- it's very difficult to conceive of the golden standard's study that has been a randomized clinical trial, that's in anyway blinded. So that, there is just almost no signs. All there is is expert opinion and a bunch of follow-up studies. And that's about it.
And in terms of the grading of scientific evidence, that kind of evidence is all the way at the bottom as compared to the gold standards which are well controlled, double blinded studies. There is none of that. Zero.

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So, as far as I --
Q That is actually my next question. Are you familiar with any controlled studies in this field?
A No.
Q Do you have a view as to why there are not controlled studies, that are able to be conducted in this field?
A Yes. I think Steve Levine, who is -- you know, has a pretty good reputation in the field -- has laid it out pretty well. He calls it an orphan diagnosis. What he means by that is that there are only a relatively few of us that are interested in taking care of these patients.
In general, the field of medicine runs away from this diagnostic group. Because the patients are very difficult. They are extremely demanding. They are hard to manage. And there is so little science. So, most physicians don't want much to do with this. Even psychiatrists.
There are relatively few psychiatrists, who have any experience and who have any

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willingness to be involved in these patients. There is no money -- almost no money for research. And the lack of research dollars has a profound impact on the field with regard to research. Because if there is no money, then the research doesn't get done.
So, the -- and then, that's one side of it. The other side of it is that it's -- you know, it's a fascinating phenomenon. So, it has drawn the interest of some people who are involved. And they -- you know, on the one side of the extreme, are the -- I think are the folks like -- what do they call themselves? WPATH -- the World Association for the something of Transgender or Transsexual's, Inc. Formally, the Harry Benjamin Society or Association.
Who, in a very compassionate way, want to do everything they can to take care of these patients. And, you know, the science doesn't mean a whole lot because these people have a condition. The condition needs to be taken care of. And you do -- they believe that everything

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they do for the patients is in the patients' best interests.
On the other side -- on the other side of the spectrum, individuals like Paul McHugh and other people, who believe it's absolutely medically unethical to destroy normal tissue. That it's unethical to alter normal hormonal -- and that these treatments are medically unethical.
So, between that schism and the fact that there is no research money, and it is an orphan diagnosis, in which relatively few people are interested in it, it has led to where we are today, to a situation where there is a condition being treated with no scientific basis.
A condition for which there are treatments for which there are no scientific basis.
Q And based on your sort of knowledge of the range of views and sort of the quantity of views that are out there, would you say that -- is Dr. McCue's view a majority view? A minority

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know, I think that's worthy of reconsidering. I don't know. I think, at this point, I could go either way.

Q And with respect to adults, do you feel as though there are ever cases where sex reassignment surgery is the appropriate course of action, for adults with Gender Identity Disorder?

A As an individual decision, yeah. I believe there are instances when, you know, it's, from a medical perspective -- from my medical perspective, that it's okay.

Q And have you managed the care of any patients, with Gender Identity Disorder, where the patient underwent sexual reassignment surgery under your care?

A Yes. Back in the seventies, when I was more involved in doing some direct care. Yes.

Q And at what point did you stop becoming involved in the direct care of patients?

A Well, I didn't stop taking in the direct care. My role, really since the eighties, has been confined to the work I do in the sexual

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behavior consultation unit at Hopkins, which I founded in 1972. Something like that. With two other people. And from which I have gotten most of my -- almost all of my clinical experience.

And my role has been confined to that -- in that -- as an evaluator of new cases. So that, around the teaching model that we have created for the interns and the residents -- for the residents and the medical students, we act as the, sort of, the beginning point, if you will, for patients who have GID.

And my particular role is as doing those initial evaluations. Because we get people from all over the country, out of our, you know, catchment area. We will do the initial evaluation and then refer them back, to where they come from, for their psychotherapy and their management. Those that are local -- we have on our staff and people in practice, who have association with us, we make referrals to those people for the continuing care of the patients.

So, if they are close by, either

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someone on our faculty will pick them up, or we make a private referral. If they are outside, we will refer back to a network of people that we have knowledge of, on a national basis. People we think have experience.

Q Prior to becoming primarily an evaluator of cases with GID, what did your clinical practice involve before then, with respect to the care of patients with GID?

A Well, you know, on a continuous basis for a period of maybe -- maybe through a period of those seven or eight years, I always had in treatment of one, two, or three patients, who had come through the evaluation process, and which I assigned to myself for the counseling slash psychotherapy. That's the beginning of the process.

Q In the course of your time directly treating patients, and as well as being an evaluator of new patients, did you ever encounter patients who had a gender identity -- by which I mean an internal sense of gender -- that was

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inconsistent with the sex role in which they had been reared?

So someone who was, for example, raised as a girl but they thought they were a boy on the inside?

A That's intrinsic to the disorder. I mean, what you are describing is most of the patients.

Q Okay. And so just so that -- again, so that's -- I'm just wanting to make sure that I sort of understand, with respect to gender identity as being something that has -- that has developed not only as a result of sort of how an individual is reared, but there is actually an internal sense that may, in fact, not have been influenced by how they are reared, because it's something that they feel different about on the inside.

Am I understanding that correctly?

A No. You completely lost me.

Q Okay. With respect to an individual's gender identity --

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had contact with her, it's very clear that the counselor was pushing the patient in the direction of identifying herself as someone with a Gender Identity Disorder, then rapidly going on the hormones.

I mean, malpractice. Just absolutely malpractice. And that's an extreme example of the kind of advocacy we do run into, and exists out there in the field.

Q And was this counselor, as far as you know, a member of the Harry Benjamin Association?

A I'm not sure. I don't know.

Q Do you know whether or not this counselor was purporting to apply the Harry Benjamin standards of care in the treatment of this patient?

A That I'm not sure of either.

Q In your view, do you believe that the Harry Benjamin Association encourages -- actively encourages people to undergo gender transition, as an affirmatively good thing as opposed to a neutral recommendation?

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A Yes. I don't think that -- I think they -- my sense of it is that the folks, associated with the Benjamin group, believe -- sincerely believe -- that that is the best treatment. That hormones and cross gender or surgical reassignment is the appropriate treatment for the disorder.

Q And do you believe that the Harry Benjamin Association is too loose in their diagnosis of Gender Identity Disorder?

MS. RUSSELL: I'm going to object to the form. But you can answer if you understand the question.

BY MS. McGOWAN:

A No. I wouldn't say that.

Q And so, for example, you mentioned that Dr. Coleman would come to your clinic and there would be lively debate. And I guess I'm curious sort of, with respect to your views, how do you think your views differ from the views of the Harry Benjamin Association?

A I think it's -- I think we are going to

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be more rigorous in placing the decision making on the individual or the patient. And probably I believe more vigorous in responding to the other -- to other psychiatric comorbidities. I mean, this patient population has a high incidence of psychiatric comorbidity.

And those comorbidities -- they represent a clinical challenge. And the challenge is trying to understand the influence of those comorbidities on the decision making, and the processes which the gender identity patients expose themselves to by approaching or, in fact, attempting to live and function in the cross gender role.

Now, you know, we are talking in generalities here. But this is an extraordinarily heterogenous group of patients. You know I have gotten to the point that, if you have seen one, you have seen one.

I think, in the years past, we used to try and pigeonhole them into stigmatized homosexuals, into asexuals, schizoid individuals,

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the truly transsexual, the autogynephillic or paraphilic transsexual, the Asian transvestite. And that all starts to -- the more you see, the more that breaks down.

They have different life stories. They have different personalities. They have different comorbidities. Their motivations and their gender are sometimes quite different. The only thing they share -- the only thing they share is the desire to live and function in the cross gender role. And that isn't in even constant. That waxes and wanes. You know, some years.

You get involved with these folks, you are talking about years of relationship. You know, for a couple of years, they are absolutely determined. Life situation changes. They stop the hormones. They start reliving in the role -- you know, their biologic sex role. It goes back and forth.

I mean, it is incredibly heterogenous. So, it's very difficult. It's very difficult for

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profoundly depressed that you should be -- you should have the depression treated first before you make this decision. Or that your life is in such chaos that maybe you ought to get your life in order before you start the hormones.

You know, I could spin it and spin it and spin it. But that is not a discouragement. I mean it's perceived, by the patient, as discouragement. And it's perceived, by the outside, as discouragement. But it's not. It's trying to put -- it's trying to put the patient in the best position possible to make a very, very important decision.

Q Okay.

A The surgeries are -- some of them can be reversed. Most of them can't. Even the hormones, there are some aspects of the hormones that are not reversible.

Q Okay.

A I mean these are not trivial decisions.

Q And, in your discussion with patients, do you also provide them information with

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possible upsides of undergoing the various steps of gender transition?

MS. RUSSELL: Objection to the form. But you can answer if you understand it.

BY MS. McGOWAN:

A You mean benefits?

Q Yes.

A I'm trying to think of how that clinically would play out. Yeah. We, for example, if we tell them -- you know, of course most patients -- most patients are pretty well versed. The internet today provides everybody with almost everything they want to know about anything.

So, most of the patients are well read. They have done a lot of research. They have been involved with transgender groups. They have friends, who have either been in the process, started, stopped, or some -- you know, occasionally they will have a relationship of some kind, a friendship with someone who has completed a transition.

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So, they come loaded with a lot of information. But even so, for example, with regard to the hormones, we review with them the effect of the hormones and what they can expect. You know, for males, they are going to get some breast development. There will be less muscle. There will be some increase in fat, but the fat distribution will be more female. They will get a more female hairline. That they may experience a change in the pitch of their voice.

So, you know, and similarly with a female to males, the testosterone is even more dramatic. It has an incredibly masculinizing effect. And you go over that with them, to let them know. Because they should and will want to -- would want to know what that is about.

So, and then, similarly with some of the surgeries, since we are seeing -- we are seeing them way down the road, way before they are getting into -- you know, they are approaching the surgeries.

But, you know, we certainly work with

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them when they are -- with those patients, who are closer to surgery, in reviewing for them what it is. You know, what they might expect. We bring in -- from time to time, we'll have -- it's very difficult to follow these patients.

So, those ones who get taken care of, go through the process, they just want to disappear into the population. Most difficult to get follow-up on female to male. Because they so successfully disappear into the population, that they don't ever want -- they don't ever want to do anything to jeopardize the fact that they have made this transition.

The males, there are enough of the males who are incredibly interesting characters, that they love to show off. So, we do get access to them. And we occasionally bring them in, and let them tell us, teach us about what it's like to be -- you know, what the transition has been, what it's done for them.

And then, for those of them who are accessible to this, you know, with certain

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unethical. Paul takes the position it's medically unethical.

I think if a plastic surgeon wants to do the plastic surgery on these patients, I don't think that it's malpractice or medically unethical. Paul and other people on that end, I think, would take that position.

Q Okay. Any other ways in which you perceive your view as being different from Paul McHugh and that end of the spectrum?

A I think that's the guts of it. I mean that's the core issue.

Q Other than this question, of whether or not it is ethical for medical providers to actually provide care to individuals with Gender Identity Disorder, how would you perceive your view as being different from those in the Paul McHugh camp, with respect to the benefits of gender transition as a course of treatment for those with Gender Identity Disorder?

A I'm thinking how Paul or others like him would deal with the issue of the follow-up

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studies, in which there are reported satisfaction results as compared -- you know, I think he would just brush them aside. Or they would just brush them aside as being non scientific. It says they would be anecdotal with a huge sampling bias.

Q And what is your view on those studies?

A Well, I think they are basically anecdotal. They are not the highest level of scientific -- as we talked about before, if you stratify scientific evidence, from class A down to class D or E, those kind of studies are way down here (gesturing).

But they are the only evidence that we have got. So, we are kind of stuck with the fact that it's far less than perfect, or far less than very scientific.

Q So, would you say that you share Dr. McCue's dissatisfaction, you know, with the science that's out there?

A No. As I said very earlier, my opinion is that the science is weak.

Q Okay. So, in --

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A I'm not going to foist that off on to Dr. McHugh. You know, I'll take responsibility for that view.

Q Okay. So, in your view, is there any credible science out there, one way or the other, about what produces an individual's gender identity?

A No.

Q And so, how have you arrived at your view of what gender identity is?

A Principally, through my clinical experience. And, of course, you know, thirty-six years of reading. A process like this really forces one to sharpen one's views, when you are under oath, and, you know, you have to be careful of what words you say and what the words mean. This has a remarkable ability to focus the concentration.

So that, you know, it's an accumulation of thirty-six years experience. Experience, reading, talking to colleagues, going to meetings. You know, this comes at the tail end

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of that thirty-six years. But it's cumulative. And – it's cumulative.

Q And, in your view, is there credible science, one way or the other, regarding the question of whether or not an individual can have a female hypothalamic sex, but male chromosomes?

A Well, I think you are talking, again, about the androgen insensitivity syndrome. And you know, fortunately, it's a pretty rare occurrence. So, in those cases, there is -- I can't -- I'm not familiar with any autopsy studies, per se, looking at the -- some of the specific morphologic changes, that can be identified in the brain, associated with the masculinization of the brain.

They may exist. But I don't know -- I have not read them. But certainly, in that instance, you have an XY configuration. And because the testosterone is blocked from the receptor sites within the brain, the brain doesn't get masculinized.

Q Any other science on this topic that

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the sex of the brain can result in what is reported to be a satisfied normally functioning person in the cross gender role.

So, I'm at a complete loss, given the reasonable rigor of the rest of his report, for him to make that statement. It's a total error in so far as I'm concerned.

Q And so, by sex of the brain, you, if I'm right, are talking about biologically as opposed to sort of psychologically, what the brain is telling the body that the sex is?

A Well, yeah. I mean, let me -- let's look at the rest of that statement. That paragraph. Once established cannot be changed. All right?

Q Right.

A All right? So, once the brain is masculinized or not masculinized, it's fixed. So, you know, it seems to me he is -- you know, in terms of the logic -- the scientific logic -- he is mis stepping all along here. I don't -- you know, unless he has a totally different

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notion of what masculinizes or doesn't masculinize the brain, that is the difference -- you know, what is a female brain, what's a male brain.

And if that's the case, then there may be consistency here. But without knowing what he means, you know, from my position, those are -- he is just flat out wrong and inconsistent.

Q And just so that I'm clear, you agree that the sex of the brain cannot be changed once it has biologically been masculinized?

A Yes. The biologic fixing is -- I would agree with him, once it's fixed, it's fixed. It cannot be changed.

Q And it's --

A At least from what we know today, you know. Who knows to the future? But there is no scientific evidence that says that, you know, after the fact, that you can re masculinize -- that you can change the masculinization process and revert to female, or take a female brain and post -- post birth, post that critical period in

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utero, when exposure or non exposure takes place, that you can change the morphology of the brain.

Q Okay. So that I'm clear, to the extent that -- if Dr. Bockting is using sex of the brain to mean the biologic morphology of the brain --

A Yes.

Q -- then you disagree with him to the extent that gender identity is the same as the biological sex of the brain.

A Correct.

Q Okay. Do you think that there is such a concept as a psychological sex of the brain?

A Well, I think -- I mean that's a -- in terms of relativism -- again, I'll go through my patient experience.

When patients are making this decision, they will, on an individual basis, based on their perception of what the cross gender role should be, they will create for themselves a set of characteristics, attitudes, and behaviors, that become consistent, internally, with what they believe should be those personalities, attitudes,

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and behaviors for their function in the cross gender role.

Not all of them do it. I mean, I've had a patient recently say I don't care. I don't care how I look. I don't care what people perceive me as. I'm not going to change my voice. I'm just going to -- I just want to live in the cross gender role. I don't care. I'm not going to try to do any of those things.

Most patients want to be perceived, by other people, as the cross gender -- in the cross gender role in an appropriate -- socially appropriate -- fashion. So, they will tailor make, for themselves, how they should act, how they should be, when they are functioning in that role.

To that extent, they are creating a psychological construct in their mind, and to the degree that part of that construct is what they think the female -- what they think the female psychologies will be if it's male to female. They will do that.

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identity is something that can be changed, at which point you used the word consolidated.

But the question originally was whether or not an individual's gender identity could be changed through therapy or other mental health treatment.

A Yeah. I think it could be consolidated in either direction, depending upon where the patient is. Many of the patients, that I have seen over the years, are ambivalent about their decisions. It's not like they are a hundred percent sure that they want to live as a male or as a female.

And a really good example of that are the aging transvestites. These are guys who have been transvestitic most of their lives. It's been a paraphilia that they have lived with, for many of them, quite successfully for – you know, beginning in -- some prepubescent, some adolescent, and then carry it on into their adult life.

Tom Wise wrote a wonderful paper, a

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number of years ago, looking at a bunch of these men and following them. And what he discovered was that their interest in changing their gender identity, living in the cross gender role, was directly related to the presence of a comorbid condition. Namely, depression.

When these guys get depressed – when a certain segment of these transvestitic men, usually in their forties and above, they get depressed. It's absolutely the new appearance. There is no prior interest, at all, in having been female. The only thing they have done is they have cross dressed for the purpose of sexual gratification. It's a paraphilia. I am assuming you know what transvestism is.

So, this group -- within the total group of transvestites, there is this sub group. But when they get depressed, they suddenly become interested in being surgically reassigned. Hormonally and surgically reassigned. You treat the depression and their desire for – their desire for changing their gender goes away.

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They have another exacerbation of their depression and all of a sudden they want to change genders again. You treat the depression, it goes away.

Q Okay.

A So, there is an example of a treatment process -- of a treatment that addresses a condition -- not directly the GID -- but impacts the GID very, very definitely.

Q And am I right that transvest -- I'm going to say this wrong -- transvestitic fetishism –

A Yes.

Q -- is a different diagnosis than Gender Identity Disorder?

A That's correct.

Q Okay. And just so that I'm clear --

A They are not mutually exclusive, though.

Q Okay.

A You can have both.

Q Okay. With Gender Identity Disorder --

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does a diagnosis of Gender Identity Disorder always indicate the presence of co-morbidities? Or are there cases where individuals can have Gender Identity Disorder without the presence of any other co-morbidities?

A Yeah. There can be. Sure.

Q Okay. In his report, Dr. Bockting cites a 1999 study of Cohen-Kettenis and Gooren, called transsexualism, a review of etiology, diagnosis, and treatment.

Are you familiar with this study?

A Yes. I think I have read it. Because it's buried, in part, in her book --

Q Um-hum.

A Where is she from? Holland? Belgium? Somewhere. And I've read the book and some of that work is in the book. She focuses mostly on adolescents.

Q So, you are familiar with the study in the context of it being cited in a book?

A Here is the guy, Zhou. That's Zhou, Z-H-O-U.

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matter of whether I agree or disagree. He is summarizing his view of what those articles are saying.

So, are you asking me if I disagree with his summary?

Q Well, yeah. I am asking, do you agree that treatment attempts aimed at changing gender identity, to become congruent with sex assigned at birth, have or have not resulted in long-term change?

Do you think that's an accurate statement, as far as the state of knowledge in your field?

A I think we have already discussed that. Where I said I think my assumption is that there are -- that there are -- there have been anecdotal studies, or case reports, in which changes have taken place. And these authors believe that it does not happen.

So, you know, you can find case studies to go either way.

Q Okay.

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A Let me see what --

(The deponent is reading the documents.)

BY MS. McGOWAN:

Q And then, let me just ask you about the two authorities that are listed in the parentheses after that statement. The first one is a 1984 publication of Cohen-Kettenis and Kuiper, K-U-I-P-E-R?

A Sure.

Q Are you familiar with that article, either in its original Dutch, apparently, or in translation?

A No.

Q Okay. And then, he also makes a citation to a --

(Ms. Russell returns to the conference room at 12:24 p.m..)

BY MS. McGOWAN:

Q -- 1965 article by Dr. Pauly. Are you familiar with that article?

A Yeah. I mean I read that years and

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years and years ago.

Q Okay. And, in your view, does Dr. Pauly's research, as encapsulated in that publication, support the view that treatment attempts to change gender identity do not result in long term change?

A Well, from this -- yeah. I think I do in terms of his sense of what he did in this review. Yes.

Q And with respect to, you know, what Dr. Pauly's sense of his review was, since I'm not familiar with the article, what do you mean?

A Well, I think he proved to himself that he thought that it is not a long-term view. But those were his cases. And he has a particular point of view.

Q Are you familiar with any scholarship responding to Dr. Pauly's findings in that study?

A No.

Q Are you familiar with the individual Kuiper, K-U-I-P-E-R, who is the author of the 1984 article?

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A No.

Q And I think we have established that -- are you familiar with Dr. Pauly?

A Yes.

Q Okay. Other than what we have discussed, do you have any basis for discounting Dr. Pauly's findings?

A No. No.

Q Okay. So, just to wrap up, with respect to answer three in your report, you, at the end of that first paragraph, say that:

This field of study is by no means settled.

So, is it your view that there is -- that it's still unsettled whether or not biology or biological factors has anything to do with gender identity?

A In my mind, no. I can't conceive, at the moment -- I cannot conceive, at the moment, visualizing how we are going to relate the biology to a social process. The gender identity, in which -- you know, I guess I have to

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with a way of doing that. The other thing to remember, these are terms that are made up. We made these terms up. Pulled them right out of the air, as a way of trying to parse out some of the issues associated with all of this. It's not like there is any historical background.

You know, we are talking about 1960's, maybe the fifties. You know, so these are made up. You know, human constructed terms that have -- that don't -- are not derived from science, per se.

Q And with respect to this question of evolving state of knowledge, I wanted to share with you an article that I found on the internet.

A Oh, good.

Q Not surprisingly.

A Not surprisingly, which we can mark exhibit thirty-seven.

MS. McGOWAN: We can mark this as exhibit thirty-seven.

(Exhibit Number 37 was marked for

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identification.)

BY MS. McGOWAN:

A May I take a look?

Q Absolutely.

(The deponent is reading the article marked as exhibit number thirty-seven.)

BY MS. McGOWAN:

Q This is an article. This is a nine page printout of an article, that appears to have been published in the Hopkins Medical News in winter of 1999, called "Sexual Healing", by Jim Duffy.

And I want to just ask you, turning to the last page -- and I apologize, it looks as though some of the punctuation in the article comes up as question marks as opposed to either commas or quotation marks.

A Well, I'm not going to do it without 'stigating the whole thing.

Q Sure.

A All right?

(The deponent is reading exhibit number

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thirty-seven.)

BY MS. McGOWAN:

A Okay. All right.

Q Okay. On the last page, there in the last paragraph, there is a comment attributed to you, that I want to first, you know, establish is something that was appropriately attributed to you, or otherwise reflects your views.

I'm going to start reading from the line that says:

The field has changed enormously since the unit began, Schmidt says. And it's going to change still more. As the scientific base of human sexuality becomes enriched, and the brain chemistry and the genetics are better understood, that it's becoming more like the other fields in medicine. That is very much to the good, in my opinion. The more interventions you have in your bag of tricks, the more patients you can help.

Is that a statement correctly attributed to you?

A I hope so.

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Q Do you recall making a statement to that effect or --

A You know, I don't remember the interview.

Q Okay.

A But this is what it is.

Q Okay. Does that statement -- is that statement an accurate reflection of your views?

A Sure. Yeah. I think I would say the same thing today.

Q How, in your -- how, in your view, has the scientific base of human sexuality become more enriched?

MS. RUSSELL: I'm going to object. Lacks foundation. I don't know how -- you haven't quite established how this relates to the issue before the court. But you can go ahead. It's just an objection.

BY MS. McGOWAN:

A Okay. State the question again.

Q Sure. You know, in this quotation, which we have established reflects your views,

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The use of low dose serotonin uptake inhibitors, for premature ejaculation, really works for some. I mean none of that existed. There was nothing.

Q And, with respect to knowledge about gender identity, what, in your view, are the most important scientific developments, if there have been any, that have informed your view about the relationship of gender identity and sex?

A From my perspective, it's mostly in the clinical realm. And, based upon my experience, this notions that the -- the heterogeneity of the patients -- when we started with gender identity, we tended to -- you know, transsexualism; you had it or you didn't.

And we made very little discrimination, with regard to the individuation of the individual circumstances of the patient's life. You know, you either had it, you didn't. And then, you went ahead and tried to work with it as best you could.

But I think the cumulative years of

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clinical experience certainly demonstrated, to me -- and I hope it's demonstrating to the field out there, that these patients are very heterogenous. And there is no one size fits all. And that they have to be worked with -- you know, you have got to create -- you have to evaluate them.

You have got to create a formulation of the base, make a diagnosis. And then, you design the treatment plan. And that treatment plan has to be trailer made, individual for the individual. That is a change from where we started.

With regard to the science, unfortunately, there has not been a lot of science. We are not much further ahead, in understanding the etiology of this disorder, whether it's biologic, whether it's a social phenomenon -- the psychology. I mean it just isn't there.

We have not done a good job of pressing ourselves, scientifically. And, as I discussed

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before, part of -- a substantial part of the reason is there just isn't any money. There is no section in NIH or NIMH, that devotes any attention to this. And the private foundations, you know --

There is a lot of money now available, because there is a lot of medications coming up, principally for females, to help them. So, the drug companies have a lot of money out there. But there is nothing from the traditional sources of funding for science, for this work. So, it's really lagged behind.

So, I don't believe -- I don't believe that we are much further ahead than we were sixteen years ago, when I made that statement, when it comes to GID.

Q Okay. And just to wrap this up, and then I think maybe we will take a lunch break, in your view, is there any credible science with respect to the relationship of gender identity and sex, that has moved the ball forward, in your view?

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A No.

Q Okay.

MS. McGOWAN: So, let's take a break here. If I can suggest we come back at 1:30. It's a little bit shorter than our normal lunch break.

MS. RUSSELL: Sure. That's fine.

MS. McGOWAN: Just so that we can keep it moving. Thank you.

(Luncheon recess -- 12:47 a.m.)

(Afternoon session -- 1:31 p.m.)

BY MS. McGOWAN:

Q So, we are now back on the record. I wanted to ask you, Dr. Schmidt, we have been trying to talk about your opinion about what is sex, in the context of your report and, obviously, your expert opinion, generally. And there have been different elements that we have discussed as part of that discussion.

In your report, you talk about sex as being a biologic reality. Or biological reality. There is also a discussion of sex in paragraph

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has one genotypic sex, and a different phenotypic sex –
A Yeah.
Q – what sex is that?
A To me, I'll say it for the fourteenth time, they are biologic males. They are biologic males.
Q So, in your view, sex is chromosomes?
A I think I have said it, you know, fourteen, fifteen times now. Yes. That's correct.
Q Wrapping up something from this morning, before we go on, I wanted to just ask you, we were talking about sort of the range of views about the topics we are discussing. And we talked about HBIGDA, the Harry Benjamin Association being at one end of the spectrum.
And am I correct that you described the Harry Benjamin view as being a minority view?
A Yes.
Q Okay. And at the other end of the spectrum, you talked about the view of Dr. McHugh

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and those who share his views, also, as a minority view. Is that correct?
A That's correct.
Q Okay. Is there a majority view?
A In so far as the field is so small, I would say -- you know, I would say there is a middle ground. Whether you want to characterize that as majority or not, you know, if we -- majority means numbers to me. Probably not.
Maybe instead of a spectrum, you know, it might be better to draw it as a triangle rather than linear, with -- you know, like I said, I believe I'm somewhere in the middle. You know, how far to the middle, whether dead center or slightly to the left, or slightly to the right, you know, you can decide.
But, you know, the model I'm drawing is a linear model with poles at each end. Now maybe, you know, you could just as well characterize it triangularly with those two poles and then another group up here, and say it's more triangular rather than linear.

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Q Is there a view that has the largest number of subscribers to it?
A I would find that hard to answer. Because I don't know anybody that has done a nose count or a head count, and actually, you know, said okay, if we somewhat artificially posit that there are three separate groups, how many are in this group, how many are in that group, and how many professionals in this group.
I don't know where I would look to find out the actual numbers.
Q Would you say that your view is held by the largest of the minorities that hold varying views?
A No. I don't think so. I think, within the field of those of us who work with these patients, I don't think that I would characterize it that way. However -- excuse me. I'm just coming off some sort of viral event. I would bet that, if we took medicine in general, and we could expose all of American physicians to these issues, I would bet that the stance that I

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take would be a majority stance with regard to today's community standard, with the approach to the care of these patients.
In that -- most physician's -- you know, physicians, our dictum is do no harm. You know, that's how we are trained. You know, do no harm. And the ethical problem for physicians is in doing harm. The harm that's done to normal tissue. I mean, the -- but I think if we could educate them – if we could educate them, I think that we could get them past that.
And where they would end up is saying that the standard of care, in the service of doing no harm, that the best that you could do, under those circumstances, is leave the decision in the hand of the patients, and not advocate for the treatments themselves. You know, these are available.
If you -- if you are psychologically, physically okay, and that you decide to do it, it's not a whole lot different than deciding you want breast augmentation, or you want to do a

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than you, I just wanted to pin down whether or not there was any disagreement between the two of you, regarding the criteria for diagnosing Gender Identity Disorder?

A No. He has abstracted – all he has mentioned here, criteria A and B, I think I go beyond that a little bit. But it's just -- no. The answer to your question is no, rather than belabor the point.

Q Okay. In question five of your report, you ask how, if at all, is GID, by which we are referring to Gender Identity Disorder, related to one sex. Similar to the question I had for you this morning, about the use of the term synonymous, I am just wondering, with respect to your use of the term related, what were you opining about with respect to how GID is related to sex?

A This is not my question. This is direct response to the questions that were given to me.

Q Okay.

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A All right?

Q Okay. So, is it -- in your report, is it fair to say that you were talking about how sex – how GID is related, if at all, to sex as a medical and scientific matter?

A All right. The question is how, if at all, is GID related to one's sex. Okay?

And my answer, you know, is probably maybe too concrete for you, but that's my answer. The relationship is that GID as a diagnosis -- the guts of the diagnosis is that; I have GID because I'm a male and I prefer to live as a female.

Q Okay.

A And I want to live as a female. And I intend to live as a female.

Q Okay. And other than your citation to the DSM, is there anything else that you are relying upon in your answer to question five?

A No. This is my opinion with regard to the question.

Q Okay. This morning we were discussing,

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briefly, the standards of care of the Harry Benjamin National Gender Dysphoria Association. And those standards of care are actually included, as exhibit three, to Dr. Bockting's report.

A I just pulled a copy off the other day for myself.

Q Okay.

A I thought they had changed. But the website -- I mean, I thought there would be some changes in the timing issues. But that's what's on the website. So, that's what I assume is current.

Q Okay. And I think you mentioned, this morning, that you are familiar with this document with the standards of care?

A I am.

Q Okay. Dr. Bockting describes these standards of care as guidelines that are, quote:

Widely accepted and respected and reflect the professional consensus about the psychiatric, psychological, medical, and surgical

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management of Gender Identity Disorders.

Do you disagree with anything in that statement?

A Yes. Widely within the field which is very small. And I would not say that they are accepted. And I don't think that they would, if tested out in the community of physicians, that they would represent a standard of care.

Q Okay. Are there other standards of care, or protocols of treatment, for individuals with Gender Identity Disorder, other than the Harry Benjamin standards of care, that are --

A That are published?

Q That are published and are more widely accepted by professionals in your field?

A I can't answer the more widely. But I'm not aware of any that are published.

Q Okay. And why, in your view, do the standards of care -- the Harry Benjamin standards of care -- not qualify as standards of care as you use the term?

A Well, because I think most physicians

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if you give me the standards, let me just briefly --
Q Here.
A Okay. I'll see if there is anything I really have a problem with.
(The deponent is reading the document.)
BY MS. McGOWAN:
A Well, I would disagree that psychotherapy is not an absolute requirement, but triadic therapy. I believe that -- you know, call it counseling or psychotherapy -- is -- should be a requirement. It used to be a requirement --
Q Okay.
A -- I think, in the previous guidelines or standards. So, that's one thing.
Q Okay.
(The deponent is reading the document.)
BY MS. McGOWAN:
A I think that's the major disagreement I have.
Q And I believe you said that you are not

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aware of any other published guidelines, for the treatment of Gender Identity Disorder, other than the Harry Benjamin standards of care.
Is that right?
A That's correct.
Q Okay. And so, are there any other standards that are not published, that health care providers treating patients with Gender Identity Disorder rely upon --
A Well, how --
Q -- to treat --
A How could they access them if they are not published?
Q Okay. So, is it fair to say that the Harry Benjamin standards are, you know, the standards that are out there to which people can look to for guidance, for treatment of Gender Identity Disorder?
A It is -- yes. It is a set of guidelines that, so far as I know, are the only ones that are published. Now, I think people have modified them. They have incorporated some

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of them in their own publications. But I think that's the source document.
Q And are you aware of any criticism of the guidelines, as such? And, again, I'm not talking about how people apply the guidelines. But I'm wondering, are you familiar with any publications criticizing the guidelines laid out in the standards of care?
A Specifically, the -- I mean, the most -- the most vocal attack is not specific to the guidelines, but it's on the whole issue of using hormones and surgery, by people like McHugh. So, to the degree that these guidelines involve the use of those procedures, it is a direct attack on the methodology of the treatment, you know.
I don't know of any -- I can't think of anybody that has specifically said that the guidelines are -- themselves are -- there is -- you know, there is something wrong with the guidelines, other than maybe others, like myself, who think that psychotherapy should be a

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requisite part of the process.
But to the degree that the guidelines layout the way that you approach using the hormones and the surgery, then if you think that's unethical, you are obviously saying that -- by implication, you are saying that the guidelines are not appropriate because they lead to something that is medically unethical.
Q And is the view that prescribing hormones, to individuals with Gender Identity Disorder, is unethical -- is that -- would you describe it as a minority view?
A Again, I don't know what the head count would be. It depends upon what you are -- what's the pool from which you are drawing?
Q The pool would be practitioners in the field of gender identity.
A Within the field of gender identity, I would say that there probably are more people that want to give the hormones than there are those that would not.
Q Okay. In paragraph five of your

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quite content in passing successfully without hormones or surgeries. I draw to your attention female impersonators. Some of them are absolutely gorgeous. Many of them -- some of them take hormones. A fair number of them don't. Most of them are not operated upon. Maybe some of them get breast augmentations.

So, it's quite variable. But, you know, you can't generalize, as I said before. It's because there are so many variations on the theme. But for those who take hormones, it does -- you know, there is a need to do that both for the morphologic changes and for the psychologic -- there is a psychologic value to it, too.

The psychology being, well, you know, now being on female hormones means, to me, that I'm more female. You know, it's a very subjective thing. I'm more female because I'm taking female hormones. And because I can tell myself that my hormonal status is consistent with the way I want to be, and, now, with my

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developing morphology.

And if you can -- you then can extend all of that to the surgery, itself. That much of the service -- I mean, there are a fair number of people, who get artificial -- who get vaginas when they never use them. But the very fact that they have a vagina creates that internal sense of consistency, that is very important in maintaining a balance, on a day to day basis, and not having to bounce back and forth between, you know, am I a male, or am I a female, or what, you know.

Q Okay.

A That's a tough position to be in if you can't resolve that. So, once you make that decision, everything that you do, that can reinforce the basic position, and support the basic position that you are now taking, is helpful.

Is very helpful in resolving the -- what has to -- the psychological work that has to be done internally, by that person, to carry the

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whole thing off.

Q So, in your view, does taking hormones have any impact on the person's sex?

A No. Not as I define sex. No.

Q And is that because your definition of sex means only chromosomes?

A Yes.

Q Okay.

A It certainly has impact on gender identity and gender role. Or sexual identity, sexual roles.

Q And --

A Well, let me say it can. Not always, but it can. Often, it does.

Q And we can probably run through these quickly. But just so that I'm clear, would you agree that patients, with GID, often have various other surgical procedures, prior to general surgery, such as breast or chest surgery, and that this is a step outlined in the standards of care?

A Well, they address breast augmentation

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in the standards. Yeah. Sure.

Q Okay. And --

A You know, we are talking about -- we are talking, for male to female, it's breast augmentation. For females, it's breast reduction.

Q Okay. And, in your view, neither breast augmentation or breast reduction has any impact on a individual's biological -- or on an individual's sex?

A No. Because you cannot change the chromosomes.

Q Okay.

A And I narrowly -- I define sex as being the chromosomal configuration, either male or female.

Q Okay.

A Let me point out to you that, in the DSM, under the section -- some of the content in schizophrenia, that there is a sentence or two that speaks to this issue of where you are going.

When pressed, people who have Gender

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For the moment, operationally, you know, as a practical matter, I accept the diagnosis. But I certainly -- I certainly -- this work, and some other things that I'm doing, is forcing me to take another look, personally and professionally, at the legitimacy of that diagnosis.

Q Okay. And what causes you to be concerned about the legitimacy of GID as a diagnosis?

A Well, there are two aspects of it. One is the heterogeneity of the patient population. It's so heterogenous it's hard for me -- first of all, I can't even envision a scientific -- a biologic basis for something that is so heterogenous. All right. So --

All right. Well, there are plenty of diagnoses, in the DSM, that have no scientific etiology at the moment. But they have certain heuristic value because they have been around for a long time. And this has been around since 1940, 1950. Not officially until 1960 something.

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That's one aspect of it.

And the other is I'm really concerned about the patient population, itself. You know, I lived through the decision to take homosexuality out of the DSM. And, you know, there were lots of good reasons for doing that. And I have the same concerns here.

I think, in the absence of there being -- in the absence of there being any kind of scientific support, vis a vis the presence of the diagnosis, other than the fact that people have been aggregated under the diagnosis, upon the basis of self report, it's stigmatizing. You know, you come -- you know, I come in. I see you. I've got a -- I am a GID. I have got a mental illness.

And with no basis for etiology for the mental illness, and the stigma that's associated with mental diagnoses, I'm not sure it should be there. I'm not so -- you know, I'm thinking we ought to give real hard thought of taking out, for the same reasons we took homosexuality out.

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And, in fact, you know -- and from a political point of view, there is a merging, now, of the agendas of the transgender with the gay and lesbian agenda, from a political basis. When this all started, years ago, the GID patients wanted absolutely nothing to do with a relationship with the gay and lesbian community. Because they did not -- they did not want to be associated.

Because they believed they had a very different -- they had a very different issue, different set of issues. And it appears, to me, that those issues are sort of merging. And the issue of stigma, I think, is going to become an increasingly important problem. I don't know what advantage there is.

I mean, there is -- so far as I can see, there is no advantage for there being a diagnosis for the population of patients. Because they could access -- there is no restriction to access of care, with the exception of poor. Poor people, who have to access

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Medicaid or Medicare.

There are some restrictions, I think, also, in commercial insurances for the treatments. But, you know, I'm not sure that would justify the -- or override the issue of the stigma. I mean, I -- you know, it's something I think we all need to think about.

Q And so, is it your view that there is no scientific evidence, one way or the other, to establish any biological cause for Gender Identity Disorder?

A There is absolutely none at this moment.

Q Okay.

A It would be very helpful if there was.

Q Is there scientific evidence sufficient to disprove any biological basis for Gender Identity Disorder?

A No.

Q So, this is still an open question?

A Absolutely.

Q Okay. With respect to the etiology of

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Q Do you think it will be possible to identify an etiology, for what is currently identified as Gender Identity Disorder, in the DSM?
A As a general category, no.
Q Okay.
A I think it's going – the work will be done by identifying, more or less, homogenous groups of patients and banging away at trying to understand the etiology for that homogenous group. I don't think we are even at the point where there is agreement, as to what the homogenous groups are.
Everybody has there own little sub classification system.
Q With respect to the -- when you talked about researchers split into camps, in your statement in paragraph six, you state others, referring to what I think is another camp of researchers, believing that there are multiple psychologic factors, child rearing practices, and or sexually motivating factors that may be at

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play in the development of Gender Identity Disorder.
Is it fair to categorize that category of researchers as individuals who adhere to the psychoanalytic school of thinking?
A No.
Q Okay. How would you distinguish sort of their view from what the psychoanalytic school would say about Gender Identity Disorder?
A I'm not an analyst. I wouldn't presume to -- I wouldn't presume to attempt to answer that question from an analytic point of view. Analytic point of view.
Q Okay. Are you familiar with the psychoanalytic theory of mental health care?
A That's an incredible question. What do you mean the theory of mental health care?
Q Would you say that you are an adherent of the psychoanalytic framework?
A No.
Q Okay. And why -- or how do your views diverge from the psychoanalytic school?

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A I couldn't tell you what the current psychoanalytic thinking is, with regard to GID. I couldn't do that. Because I'm not interested in that. Because it's just too confining. Too confining a framework with which to approach patients. I'm much more eclectic, if you will. I don't ascribe to the psychoanalytic theory.
Q Okay.
A I mean not that it doesn't have some utility, or hasn't had some utility. But I think we are way past that.
Q Okay. I want to just run through a few of the studies that Dr. Bockting mentions in his report. Just to get your view if you are familiar with them. And, actually, let me make sure I can point you to the right report. Yeah.
In his report, at page fifteen in paragraph thirty-four, Dr. Bockting notes:
That in recent years prenatal exposure of the brain to androgens has increasingly been put forward as a critical factor in gender identity, citing the 1997 study of Diamond and

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Sigmundson, called; "Sex Reassignment at Birth, Long-term Review and Clinical Implications".
Are you familiar with this study?
A I don't think I have -- I don't think I have -- no. I have not read that particular study.
Q Okay.
A But it's -- no. Never mind. It's -- no.
Q Okay. In his supplemental report, Dr. Bockting, at paragraph four, discusses recent research on the etiology of transsexualism as pointing toward the role of sexual differentiation in the brain -- or sexual differentiation of the brain, as a factor in gender identity development.
And in support of that statement, he cites a 2000 study of Dr. Kruijver, K-R-U-I-J-V-E-R, called "Male to Female Transsexuals have Female Neuron Numbers in a Limbic Nucleus".
Are you familiar with this study?

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A No.
Q You state here that, you know, plastic surgeries are procedures that alter the morphology of an individual's body. Would you agree that there are surgical procedures, that are part of gender transition, that are not plastic surgery procedures?
A Yes. I think the removal of the ovaries and the uterus are gynecologic -- I put them in gynecologic. But I think that's -- okay. Yes. I would say they are gynecologic.
Q Okay. And so, am I correct that, in your view, not withstanding any of the surgical procedures that an individual may undergo as part of a gender transition, your view is that one never changes their biological sex?
A Correct.
Q Okay. Because none of those surgeries change an individual's chromosomes. Correct?
A Correct.
Q Okay.
A Nor could they.

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Q Okay. Do you think that a person, who has undergone sexual reassignment surgery, should be allowed to change the sex designation on their birth certificate?
MS. RUSSELL: Objection. Relevance. But you can answer.
BY MS. McGOWAN:
A That's a legal issue defined by each state. And, you know, I can't -- I wouldn't disagree with a state deciding that that could be done.
Q And is there a point at which you believe individuals should be allowed to change their sex on government documents?
MS. RUSSELL: Same objection.
BY MS. McGOWAN:
A No. I think that -- you know, that should be defined by the regulations, or whatever, of the State that pertain to that change.
Q With respect to questions eleven and twelve, which pertain to your opinions about

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intersex conditions --
A Yes.
Q -- is there anything else, with respect to your opinion, about those questions that you intend to offer in this case?
A No. I don't think so.
Q Okay.
A Let me just make sure and read the questions themselves. Make sure that those were decent answers.
(The deponent is reading the document.)
BY MS. McGOWAN:
A I'm getting there. No. I don't think I have more to say about that.
Q Okay. Are all intersex conditions the result of genetic abnormalities?
A The only other category could be congenital. I don't think I know of any -- I don't think I -- I don't know of any congenital, non genetic syndromes, or situations that cause intersex. Not that there -- you know, that there couldn't be, theoretically. But I don't know of

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any.
Q Okay. And just so I'm clear, are you aware of any cases where a child has ambiguous genitalia, but clear normal either XX or XY chromosomes?
A Say that again.
Q Sure. Are there any cases in which an intersex individual, or an intersex child, has ambiguous genitalia, but does not have abnormal chromosomal structures? They are either definitively XX or XY?
A Oh, oh, no. No. Sure. There are the -- the Klinefelters XXY, XXXY. I think there are XY's with partial or incomplete Y's. I mean there are all kinds of translocations. Not ranslocations, but variations on the X -- the direct X and Y.
So, I think there are a fair number -- there are a number of chromosomal conditions that are aberrant, in that it's not just XY or XX. They are -- I forget the term. As I said, something like Klinefelter Syndrome, which is

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Q Do you recall having any conversations -- before you do that -- with the government about any of your -- any particular answer that you provided to the questions that they posed to you?
A I think the -- no. I don't recall any specific conversation. No.
Q Did you have or did you produce any -- other than the document that you are looking at right now, exhibit thirty-nine, did you produce any other drafts of your answers to the questions posed by the government?
A No.
Q Okay. Did the government, during any of your conversations with them, suggest certain statements that -- or issues that they needed you to address in your report, other than what's reflected in these e-mails?
A The only thing, in addition to these questions, was they asked me about if I would address Judge Robertson's position as expressed by this section in my report. They asked me to

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think about that and what my thoughts were about it.
Q Okay.
A And then, you have my thoughts about it as part of the -- as part of the report, which stands -- you know, which is not direct -- it's not in this question list.
Q Okay. And did counsel for the government provide you with any documents about this case?
A Yes. Yeah. They did. I got them here. You have already -- they are -- as part of the packages, they had Dr. Bockting's original report and, later on, the supplement. And then, they also supplied me with the complaint.
Q Um-hum?
A Okay? And what else do we have here?
(The deponent is looking through a box of documents.)
BY MS. McGOWAN:
A An expert report by Martha Harris, LCSW.

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Q Okay.
A And Dr. Bockting.
(The deponent is looking through documents.)
BY MS. McGOWAN:
A I'm not sure what you call this. Oh, here we go. Yeah. It's called a memorandum of order.
Q Okay.
A Okay?
Q And the witness is referring to a copy of the decision of Judge Robertson on the motion to dismiss in this case?
A Yeah. I think those were the documents.
Q Okay. Did you review any other documents in preparing your report?
A Could you be more precise about review? I mean, I certainly spent a fair amount of time on the DSM IV.
Q Okay.
A And the TR. Because I had to quote

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directly from that.
Q Okay.
A You know. And as well as you think you know something like that, you have to read it and reread it.
Q Okay.
A I did some general reading from Ken Zucker and Sue Bradley's book on some of their introductory chapters just to refresh my memory. And some of the chapters they have on -- on notions of etiology. I like their book because I have had some contact with Dr. Zucker. And I think well of him.
Q Okay. And if I'm right, that's the 1995 book by Zucker?
A And Bradley.
Q And Bradley, that you cite in your report?
A Correct.
Q Did you review any research, published after 1995, in your preparation of this report?
A Well, about four years ago, I thought I

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an expert on either Gender Identity Disorder or transsexuality?
A No. No.
Q Okay.
A You can see the bulk of them. I can tell you what they are. I'll give you the short version. I have been doing forensic work. I'm not a forensic psychiatrist. But, many years ago, I started working with the public defender, on the indefinite commitment law to the Patuxent here.
And some work had shown that that particular program, the recidivism rate was no better than just the general prison population. And these guys were put into prison without any definite sentencing, with the hope that the programs there would make them different than other prisoners or criminals, and they would have a lower recidivism rate.
The public defender even took that on. And I got my feet wet in doing this kind of work, working with the public defender. Because of

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that, I started getting cases with -- you know, it's all networking. And I started getting cases. And it has just built to the point where I get anywhere from ten to twelve cases a year.
Most of them mature to depositions. Only one or two of them go to trial in a year. Most of them are settled. The overwhelming majority of them are malpractice. The overwhelming majority -- ninety percent of the cases, I'm on the defense side in malpractice.
Most of the cases have to do with suicide. There are some that have to do with other kinds of treatment issues. A couple of criminal cases. A couple cases both on you guys' side against you guys.
Q By you guys, the witness is pointing to --
A The attorney general. The attorney general.
Q -- the government whereas --
A With the issue of fraudulent billing because I have some expertise in CPT coding and

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documentation. So, you know, if you say I've been doing this for thirty years, at the rate of maybe ten, twelve cases a year, even though I'm not a forensic psychiatrist, I've logged a lot of experience. But most of it has been in the area of malpractice.
Q Okay. And with respect to the Koselik case in Massachusetts, what was the opinion that you were offering?
A I can't talk to you about it.
Q Okay. That's covered by the gag order in the case?
A Yes.
Q Okay. And with respect to the IRS case that you mentioned, are you at liberty to discuss the opinion you offered in that case?
A I haven't offered any opinion yet. I am in the process of doing that right now.
Q Okay. And what questions were you asked to opine on?
A If I understand, there is a technical issue -- there is a technical issue in the

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regulations with regard to being able to take deductions for medical surgical procedures. And the issue there -- again, you know, I probably got it all wrong.
But the issue, from a legal point of view, is whether the -- it boils down to whether the surgery is medically necessary or elective, as that discrimination applies to the technical aspects, or the technical components, and what was the congressional intent in writing those rates.
Q Okay. And have you formulated your opinion about whether or not sex reassignment surgery is a medically necessary procedure?
A Yes. I think I have given you that answer today in many different ways. In my opinion, it's elective surgery.
Q Okay. And did you bring any other documents with you today, other than the documents that you have identified?
A I did bring -- you said, you know, to try and comply. I did bring my written drafts.

ACKNOWLEDGMENT OF DEPONENT

I, CHESTER SCMIDT, M.D., do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me and any corrections appear on the attached Errata sheet signed by me.

_____

(SIGNATURE)

_____

(DATE)

CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Bracha Goldberger, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 21st day of February 2007.

My commission expires:
August 1, 2009

_____

NOTARY PUBLIC IN AND FOR
THE STATE OF MARYLAND