Attachment C

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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PROCEEDINGS

Whereupon,
CHESTER SCHMIDT, M.D.,
was called as a witness by counsel for Plaintiff, and having been duly sworn, by the Notary Public, was examined and testified as follows:
EXAMINATION BY COUNSEL FOR PLAINTIFF DIANE J. SCHROER:
BY MS. McGOWAN:
Q Good morning, Dr. Schmidt, my name is Sharon McGowan. And I am here with my colleague, Ken Choe. And we represent the plaintiff, in Schroer versus Billington. And we are here, this morning, to take your deposition.
Have you ever been deposed before?
A Yes.
Q Okay. And so, you may be familiar with these instructions, but I'll just run through them quickly. I'll ask you a series of questions, today, that you will answer under oath, as you have just been sworn.
And the court reporter will take it all

A Yes.
Q I would like to go through the expert opinions that you offer, in this case, as stated in your report. We'll start with page three. There is a list of questions that are laid out. And I would like to just go through each one.
A Okay.
Q In order to live up to my reputation of being meticulous and thorough.
So, with respect to the first question, where it's laid out what is meant by the term sex. First, let me just ask you, what do you mean by the term sex?
A What I mean, by the term sex, it refers to the biologic status, principally the gonadal status, of an individual. And that is the term. And that gonadal status is determined, primarily, by the chromosomes, XX for the female and XY for the male.
Q And, in your report, you used -- today, you have talked about gonadal status. And, in your report, you mentioned gonadal assignment.

Do you mean different things by those terms?
A No.
Q Okay. And so, by gonadal status or gonadal assignment, what do you mean by that term?
A What it means is what the gonads of the individual are.
Q Okay. And so that I'm clear, is your opinion that sex is gonadal assignment, or that sex is chromosomal configuration, or something else?
A Well, sex is primarily the chromosomal configuration of the individual which, of course, is then expressed by the production of the gonads, as determined by the genetics or the chromosomes. The genes that are on the chromosomes.
Q And when you say that sex is primarily chromosomal, other than chromosomes, what else is a part of sex?
A Well, you could include the internal

genitalia, the external genitalia. I think, for the male, I think there is the Y chromosome produces an HY androgen that's part of sex determination.
So that, there are other biologic elements that, again, are driven primarily by the chromosomes on the XX and XY -- by the genes that are on the XX and XY chromosomes.
Q And what else is meant by the term sex, if anything?
A I don't know what you mean. I mean you can -- you know, you asked me what it means for me. And that's what it means for me.
Q Okay. And so just that I'm clear, when we talked about chromosomal assignment -- I'm sorry -- chromosomal configuration, in your view, is part of sex.
Correct?
A I don't think I said it's part of.
Q Okay.
A So, I don't know what you mean by part of.

Q Other than -- just to backup, because I believe your answer said that chromosomes -- or that sex was primarily a reflection of chromosomes. And so --
A Correct.
Q -- I'm just trying to make sure I understand, in addition to chromosomes as the primary thing, what else is included in the field of things that constitutes sex?
A I don't think I can say more than I have said. I mean I can repeat my answer. But I think that is pretty much --
Q Okay.
A Pretty much my understanding -- my understanding of what is meant by sex.
Q Is there any aspect of sex that is not, in your view, driven primarily by chromosomes?
A With regard to the term sex, itself?
Q Yes.
A No.
Q Okay. And what is the basis for your opinion about the meaning of sex?

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

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

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.

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.

A Okay.
MS. McGOWAN: So, this will be exhibit number thirty-five.
(Exhibit Number 35 was marked for identification.)
BY MS. McGOWAN:
Q In paragraph two of Dr. Bockting's supplemental report, he says -- and certainly if you understand him to say something different, please, let me know.
But, in paragraph two of his report, Dr. Bockting discusses of the work of John Money, including the 1972 work, upon which you relied in your report. And he states that both John Money's work, from 1972, and his later work from 1994, actually says that:
Sex is a multi -- is multifaceted and includes not only chromosomes, but also gonadal sex; fetal hormonal sex; and, in parenthesis meaning prenatal hormonal -- I'm sorry -- prenatal hormones produced by the gonads;

internal morphologic sex, and in parenthesis internal genitalia, ie: ovaries, uterus and testes; external morphologic sex, by which he has in parenthesis external genitalia, ie: penis, clitoris, vulva; hypothalamic sex, being sex of the brain; sex of assignment in rearing; pubertal hormonal sex; as well as gender identity and role.
Do you disagree that Dr. Money considered all of these aspects to be part of a person's sex?
A I would have to go back and look at the specifics. There are two things mixed in here. One is the -- one are the biologic elements, with which I have no disagreement, to include --
As I said in an earlier answer, I would have no argument with including, in sex as being a biologic issue, of gonadal sex, prenatal hormone environment, internal morphologic -- that is the internal genitalia, the external genitalia, the hypothalamic access, the -- what happens during puberty with regard to hormonal

changes.
I would agree that they could all be included in what I believe to be the concept of sex. I do not accept the notion of sex of assignment in rearing and gender role and identity. Because those are social constructs that have been created, you know, and are not related to the specific biology.
Q And so of this list, that Dr. Bockting includes, just so that I'm clear, it is sex of assignment and rearing and gender identity and role are the two elements, of this list, where you and Dr. Bockting disagree, as far as whether or not they should be included in the definition of sex?
A Well, there are four specific concepts here; assignment, rearing, identity, and role.
Q Okay.
A Gender identity and role. I would not -- I do not include them in my definition of sex.
Q Okay. But you would agree that

hypothalamic sex is something that you would include in the definition of sex?
A Yes. It's part of the biology. Yes.
Q Is hypothalamic sex something that is driven primarily by chromosomes?
A Yes.
Q Okay. How so?
A Because it's the brain. The brain. And the brain is driven -- was created by the genetic -- by the genes.
The notion of there being a male or female brain is based upon the fact that, during fetal life, if you have a Y chromosome, the genital ridge differentiates from being a female genital ridge into a male genital ridge. And part of that differentiation is the production of testosterone.
So that, as a fetus, the male fetus is then exposed to testosterone, which masculinizes the brain. And a good part of that is effective in the hypothalamus. So that, the hypothalamic access of the brain is effected by the fetal

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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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Q Half were comfortable with being raised as girls, and had a female gender identity. And roughly half were not, and reverted back to being boys.
A Correct.
Q And so my question is, you know -- my question to you is, what is the significance of the fact that half of the subjects, who had male chromosomes, had female gender identities?
A Well, I think I just laid it out for you. That, you know, my opinion is that the -- what you draw from that observation, with regard to gender identity, is that the process of -- the process of creating the gender identity in the child can override the biology. The biology being the fact of the existence of the XY.
Q In Mignon's study, were the results also mixed, where some children reverted back to the gender identity of -- consistent with the chromosomes whereas others did not?
A Yeah. A couple did, but not in the number or the percentage in Bill's study -- in

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Reiner's study. And, also, there were multiple inter -- there were many different kinds of intersex conditions. In Dr. Reiner's study, there is a single condition.
Q And Mignon's study, it's -- just to be clear, there were fewer subjects who reverted back to the gender identity that was congruent with their chromosomes --
A Yes.
Q -- than the number that reverted back in --
A That's correct.
Q -- Dr. Reiner's study?
A Correct.
Q Okay.
A Yes.
Q And are you familiar with any articles or scholarship responding or reacting to Dr. Reiner's study?
A No. I haven't -- I haven't read anything. No.
Q Okay. And are you familiar with any

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articles or scholarship responding or reacting to the Mignon study?
A No.
Q In paragraph three, also of your report, keeping our focus on that, in that second paragraph, I wanted to focus on the statement, which I'll just read here. The statement says:
Individuals who -- or, actually, I'm sorry. I was going to focus on something else for a moment first. The statement I wanted to ask you about is -- and I will -- I'm going to -- well, we can just sort of read the paragraph. Then I'll ask you the question.
This is: Individuals who declare themselves dissatisfied with their sexual, and in parenthesis gender identity, who take steps to live in the cross gender role, are normal XX females or XY males with normal external and internal genitalia, if they take cross gender hormones, and undergo any or all of the currently available sex reassignment surgeries, they do not change their biologic sex. They do change their

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sexual identity.
With respect to your statement that individuals who take cross gender hormones, or undergo any or all of the currently available sex reassignment surgeries, still do not change their biologic sex, what is your basis for that opinion?
A Well, that's tough to answer because it's so obvious. There is nothing that is done to them that changes the -- you can't change the XY or XY configuration. There is no way to do that. These are all external things. You know, these surgeries are external. The hormones, themselves, have no direct bearing. I mean, you can't change your chrom -- you can't change your chromosomes.
Q Okay. And is there any difference between the terms sex and biologic sex, as you are using them?
A No.
Q Okay. So that I'm clear, are you saying that an individual's hormones are not part

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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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MS. RUSSELL: I'm going to object to the form of the question. But you can answer if you understand that.
BY MS. McGOWAN:
A I will tell you most of my colleagues would do that. They would be, I think, transsexuality Jon Meyer, Tom Wise.
Q I'm sorry, John Meyer. And who is the second person?
A Tom Wise.
Q Tom Wise. Um-hum.
A I cite those two because they have done some of the writing, but there are others. But I, you know, because they haven't -- they haven't had the scientific publications. So, I wouldn't cite them.
Q And are these colleagues of yours at Johns Hopkins?
A Yes. I think Paul McHugh would take that position.
Q Okay.
A And beyond that, I didn't prepare for a

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list. You know, for further discussion at another time, you know, if you want me to research it, I could probably do that.
Q For purposes of today, can you identify anyone not affiliated with Johns Hopkins, who shares that view?
A For today, no. No.
Q Okay. Other than Dr. Meyer, Dr. Wise and Dr. McHugh, are you familiar with anyone else who has published conclusions consistent with your view?
MS. RUSSELL: Objection to the form.
BY MS. McGOWAN:
A I can't cite any specific -- anything specific today.
Q Okay. Are there scholars who take a different view than yours?
A Yes. Sure.
Q Is your position --
A Although I must say --
Q I'm sorry.
A I'm not so sure it's -- I'm not sure --

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I'm not certain because of the -- at least my reading of the literature is such that the nuance, in terms of the precision of the definitions, is not really well based in the literature.
You know, there is a lot of -- there is substantial cleavage in the field, I think, between -- I mean, there are such extremes that are driven by not only the science -- of course, the science is extraordinarily weak, but between the science driven more by the clinical issues.
And there are such extremes that I can't think of any literature, in which there has been rational discussion by experts, of the nuances of definitional terms and the importance or the effect of those terms, on either research as science or on clinical -- on clinical process. I can't think of a single discussion.
I mean, the only -- there are only two debates that I am aware of, that I have been able to uncover. One was the one a couple of years ago in the APA, regarding the diagnosis. And

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then, there is a very interesting debate between Paul Blanchard and Paul Federoff, both of the Clark Institute, which is part of their publications.
It's not -- it emanates directly from the Clark Institute, which they take different sides on the issue of how you are to manage Gender Identity Disorders. But even in that discussion, there is nothing that really deals, as specifically with the questions that you raise, that deal with the nuances of definition.
So, I don't know how that answers your question, or whether it does answer your question. I would say there is very little in the literature, that we could point to, that would make either you or I comfortable, from a scientific point of view, as to whether these are settled issues or not.
Q And well, I guess one thing, let me just ask you. When you talk about -- you made reference to the fact that the science, in this area, is weak -- I think was the term that you

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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 --

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

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 --

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

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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you are familiar with?
A That I could cite today, no. But I know that there is -- Zhou or somebody who has done some studies.
THE COURT REPORTER: I'm sorry, Zhou what?
THE DEPONENT: I think his name is Zhou.
BY MS. McGOWAN:
A And I looked at them. But they weren't particularly meaningful for me. I didn't think much of them. So -- but that's all I can say about it today.
Q Do you recall why you didn't think much of it? Were the studies not peer reviewed?
A No. They were peer reviewed. I just didn't -- they just didn't speak to me as they say.
Q And are you familiar or are you -- do you know of any credible evidence -- scientific evidence -- of whether or not gender identity is or is not a factor in determining sex?

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A No. How could that be? I mean, from my point of view, gender identity and sex are different. One is a biologic reality. The other one is a social process. I mean, your question doesn't make sense to me because of my opinion and my view.
Q Before I move on, is there any other way in which you perceive your views to be different from Paul McHugh and those at that end of the spectrum, as you have described it?
A No. But I'm sure there are. But you would have to ask some specific questions. I can't conjure that up for you.
Q Okay. As we go throughout the day, we'll see if there are places we can explore that further.
With respect to gender identity, in his report -- and I'm sorry -- okay.
In Dr. Bockting's report, which is exhibit thirty-six, at page five, sub paragraph B, Dr. Bockting states that:
Gender identity is believed to be

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established early in life by the ages of two to three years.
Do you disagree with that statement?
A No.
Q And in -- let me make sure I can point you to the right place, so that there is no dispute about the part of Dr. Bockting's report that I am asking you about. On page fourteen of Dr. Bockting's report, which is paragraph thirty-two, Dr. Bockting says in this report, and then I believe he sort of reiterates it in his supplemental report, that:
Gender identity can be viewed as the sex of the brain which, once established, cannot be changed.
Do you disagree with that statement?
A Let me find it.
Q In paragraph thirty-two, it's the third line on to the fourth.
A I'm reading the whole thing with the context.
Q Sure.

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(The deponent is reading the document.)
BY MS. McGOWAN:
A No. I don't agree with that.
Q Okay.
A No.
Q What is the basis for your disagreement?
A Well, everything that I have said before. I mean, he -- if I read this correctly, in this context, gender identity can be viewed as the sex of the brain. He is stating, to me, that the gender identity is a direct consequence of the sex of the brain. And I think that's totally incorrect.
I believe that the gender identity is a social process and is not related to the sex of the brain. And if we trace back to earlier testimony, that disassociation or that difference is clearly manifested in the intersex conditions, and the treatment of those intersex conditions, where the sex of the brain can be completely overridden, and a gender identity discordant with

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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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Q So, just to wrap up this question with regard to the 1999 study of Cohen-Kettenis and Gooren, have you actually read the study or are you familiar with it only in the context of it being cited in a book by --
A In her book, yeah.
Q Okay. And I'm sorry, by her, who are you referring to?
A The lead author.
Q Oh, Cohen-Kettenis?
A Yes. Cohen-Kettenis.
Q Okay. I'm sorry.
A I believe that's her name if that is the book.
Q So, are you familiar with the findings of this study?
A I don't remember them specifically. Why don't you just take me to where he cites it and that will give me a clue?
Q Sure. On page fourteen of Dr. Bockting's opening report, which is exhibit thirty-six.

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A All right.
Q Exhibit -- oh, it's on page fourteen.
A Um-hum?
Q Paragraph thirty-two, he cites Cohen-Kettenis and Gooren's 1999 study for the statement; gender identity once established cannot be changed.
And we have already established the earlier disagreement you have with him, regarding the use of gender identity as though it's sex of the brain.
A Okay.
Q From a biological standpoint.
A Yeah. Well --
Q So, I'm curious, if you are familiar with this 1994 study, that he is citing?
A I'm not -- I don't even know -- I can't believe that it speaks to that issue. That's so convoluted of a statement.
Q On page twenty, there is a list of his references --
A Yeah.

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Q -- where he actually lays out the specific citation to the 1999 study of Cohen-Kettenis and Gooren.
A Yeah. She is the author of the book. Here it is on 2003. This Thousand Oaks, CA, I assume is the publisher. Now, which --
Q On two up from there, is a 1999 study in the Journal of Psychosomatic Research. And my question was if you were familiar with that publication?
A Specifically, no. But I would be -- I would be hard pressed to believe that there is anything in there of value, regarding the etiology, scientifically. There is nothing. There is just nothing out there.
Q Is the Journal of Psychosomatic Research a peer reviewed journal?
A Sure.
Q And are Cohen-Kettenis and Gooren people who are well regarded in the field of gender identity research?
A I don't know them very well. She has

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done the book, though. I am assuming that she has some authority in the field.
Q Okay.
A Listen, if the etiology -- if there is any guess as to the etiology, it would be in big lights all over the world and the country. It ain't there. It just ain't there.
Q So, in your view, this is still a very open question with respect to the etiology?
A Right. I would say that science is in its -- it may be in the fetal stage of development.
Q In the next sentence in his report, Dr. Bockting cites two studies in support of a statement:
Treatment attempts aimed at changing gender identity, to become congruent with sex assigned at birth, have not resulted in long-term change.
First, let me ask you, do you agree with that statement?
A Well, he is summarizing. It's not a

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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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keep saying it over and over again -- in my opinion, is a social process. That is not biological. It's social.

So that, I don't see -- I don't see how we can -- I can't conceive of how, at the moment -- not to say it couldn't be done in the future. Who knows? There might be some way of pulling it together. But, at the moment, I don't see a way of relating a social process directly to the biologic process.

Q Okay.

A Yeah. I'll stop there.

Q So, in your view, is the science definitive that gender identity is only a social process, and not, in anyway, linked to biological processes?

A No. No. I mean, to do that study -- to do those kinds of studies, you would have to -- I think there are some clues in these follow-up studies. I forget which one. There is a one liner, in which -- I think it's in the Mignon study, in which there is a one liner about

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the folks, who did the study, make a statement of concern about the consistency in which the -- the consistency of the gender identification process is applied to the children in those studies.

John Money's -- John Money's, you know, in the end of his career and his life, came all apart. Because he falsified the data on a study that was central to his thesis. You know, the book by Diamond. Have you read that book? That's not fair. I am not supposed to ask questions.

Anyway, in one of his famous case studies, he clearly hid and falsified data that indicated that the twin brother, whose penis had been burned off during circumcision -- and there was attempt to raise that child in the cross gender role as a female. And it failed miserably.

The person eventually reverted to male and then killed himself. And then, going back into the data, it was clear that the family was a chaotic dysfunctional family. And there was no

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consistency in the gender identification process of the child. So, it was -- to me, there is no wonder that that person had enormous difficulties, in terms of not only the gender identity, but in terms of many other aspects of their life.

So, there are -- for me, there are at least two examples of where research could go. But how the hell would you do the study? You would actually have to take an observer, and put them in the family, from the day the kid came home, until they achieved some sort of maturity, to see if the family, the parents or the caregivers, the extended family, was consistent in its message with regard to the gender identification process. That's almost impossible.

But that's the kind of thinking, I mean, I indulge in. In thinking how will you test -- how would you test, scientifically, the gender identification process, and the impact of consistency versus inconsistency.

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You know, the other great case example -- of course, it didn't work out in terms of -- well, we don't know -- you know, Hemingway was cross dressed by his mother for an extended period of time during infancy. And he had enormous problems. You know, probably more -- he was probably more homophobic than he was confused about his gender.

But, you know, that kind of inconsistent message. Inconsistency within the family and inconsistent across cultural lines, between the family and the community, have never -- you know, it's -- they have to be studied. But I don't know how we can ever get to the studies.

Q So, is it your view that, because you can't actually control for the social factors, it's, in your view, virtually impossible to actually engage in a study to determine whether or not there are biological influences on gender identity?

A Well, somebody clever may well come up

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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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one -- or answer number one -- of sex being gonadal assignment at birth. And then, we have obviously also talked about sex as chromosomes.

And so, I guess I am trying to get my handle on sort of what is your opinion, as far as what is sex? Is it all of these things? Some of them?

A All of them? What do you mean by all?

Q Well, with respect to -- when you say sex is a biological reality, what do you mean by that?

A Same answer I gave before. It's based on the chromosomes and the genes on those chromosomes; XX, XY.

Q And is that it?

A Pretty much it.

Q Okay. But with respect to pretty much, is there anything else, even if it's only a small part that's part of sex?

A Well, I think I -- you pointed me to Dr. Bockting's inclusion of some other factors. I see those things as, okay, I can include those.

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But they are consequences of the chromosomes in the genes. Okay?

So, you know, I wouldn't -- I'm not going to argue that those things are related to the -- or have a relationship to my definition of sex. Because they are also biologic. They are biologic consequences of the chromosomes and the genes that are involved.

Q Okay. And so, when some biological factors are female and some biological factors, including chromosomes, for example, are male, what sex is that person?

A You have asked that before. I mean, is there anything different that you want me to repeat the answer?

Q Yes, please.

A All right. Now, which biologic -- when you say biologic, what is male and what is female?

Q Well, let's say this, if chromosomes -- if the chromosomes are XY --

A Yes.

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Q -- and all other biological factors -- and if you can help me, maybe, spell out what all those are so I'm not missing anything. But if all other biological factors are female, what sex would that person be?

A We are talking -- the only -- the principle intersex condition, that I'm aware of, in which that kind of stark disassociation between, where you can get external female genitalia, and you don't get any internal genitalia, with the androgen insensitivity syndrome, I believe.

I don't think there are formed ovaries. I don't think there is a uterus. Maybe a uterus, but no ovaries, I think. And you don't get -- you don't get complete -- you may have partial exposure of the brain to testosterone. It's the androgen insensitivity syndrome.

So, there is a group of them. Because there is varying penetration of the malfunctioning gene, in terms of how much of the testosterone gets to the appropriate receptor

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sites. So, in that rare intersex condition, I would posit that, biologically, the person is -- the genotype is male. The phenotype is female.

And in my definition, because the genes don't do what they are supposed to do, so you get a phenotypic female, but is basically a biologic male, genotypically.

Do you understand it when I use genotype versus phenotype? Genotype is what are the genes or the chromosomes. The phenotype is the expression of those genes and chromosomes. And in the incidence that we are talking about, this androgen insensitivity syndrome, the appropriate, the proper, the normal manifestation of those genes do not get expressed, because there is a lacking.

I believe it's an absence of a particular enzyme that blocks the -- that doesn't lead to appropriate receptor site. The receptors do not act appropriately to the presence of the testosterone.

Q So, in that case, where an individual

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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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report, as part of your answer --
A Now, of course, as you know, I'm going to make -- so that doesn't get spun in anyway, I have already included myself in the group that gives the -- that supports the hormones for the obvious -- you know, for the cases I think it's appropriate for.
Q Yeah.
A All right?
Q Right.
A Okay.
Q Because you do not consider yourself to be in the Paul McHugh camp?
A That's correct.
Q Okay. In paragraph five of your report, or answer number five to your report, you say that individuals, who are diagnosed with Gender Identity Disorder, wish to adopt the opposite sexual identity and adopting the opposite sexual role does not change one's biologic sex.
And I just want to make sure that I'm

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clear. What do you mean when you say adopting the opposite biological -- I'm sorry -- adopting the opposite sexual role? What are you including when you use that phrase?
A Well, it's two part. You have the person chooses to live in the cross gender role. And in such, to create consistency, they both assume the cross gender identity, the sexual identity, which remember we said we were going to use the same word.
And to the degree that it suits their purpose, they will try -- in my experience, what they try to do is create a gender role, or a sexual role, that is consistent with the gender identity. And that sexual -- that sexual and gender role is their sense of what is expected of them, and how to behave and act, and attitudes, etcetera, in -- now living in the cross gender role.
So, if I choose, as a male, to transition into a female, into a female gender identity -- and for the most part, most of the

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patients will construct for themselves a set of behaviors that they believe are consistent with the female role, for the culture in which they find themselves.
Q Okay.
A Now, I gave you one exception. You know, this one case where he could care less.
Q Okay. So, in your view, are those patients, who transition pursuant to the steps laid out in the standards of care, simply adopting the opposite sexual role?
A Sure. They are choosing -- they make a choice. A conscious choice.
Q Right. And so, for example, hormone therapy, which is laid out as a step in the standards of care -- correct?
A Yes.
Q In your view, is taking hormones simply a form of adopting an opposite sexual role?
A Well, for them, it furthers -- it furthers that adaptation. Because -- it does lots of things. And it does different things for

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different people. There is the -- some of the morphologic differences are very meaningful in helping the person consolidate into the new gender role.
Because -- I mean, you can't walk around, day after day, being ambiguous about your gender identity. It will tear you apart, psychologically. So, once you have made the decision, that you are going to live and function in the cross gender role, there has to be some constancy and consistency. And the hormones go a long way to doing that.
Now, there are patients, who transition, who never take hormones. Never get surgery. And they do very well. They decide I'm going to dress -- I'm going to dress, use make-up, a little electrolysis. And they happen, some of them, to, you know, be slight in build and are kind of pretty males, anyway, to begin with.
And they don't even need hormones, some of them. And they don't want them. And they are

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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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Identity Disorder don't tell you that they are a different sex, in terms of the biology. Because if they did, they would be delusional. And they would have a different disorder. And that is laid out in the DSM.

I mean, it's a world of difference between a patient who says, look, I've made this -- this is what I prefer, this is the way I am going to live. If you press them, they are not going to tell you that my -- you know, I was an XY, now I'm an XX. They are not going to do that. If they do, it is delusional thinking. And there is another problem here.

Q Okay. With respect to question number six in your report, which is -- the question is:

What is the scientific etiology regarding GID?

And we have talked, this morning, somewhat, about etiology of sex and gender identity. And just to make sure I close the loop, what is your opinion regarding the state of scientific knowledge, regarding the etiology of

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GID?

A It's limited.

Q Okay. And is it your view that it's based only on case studies?

A No. I mean, you are going to point to these studies by Zhou, that are -- you know, are not very convincing to me, and certainly hasn't moved the field very far. But they are limited. You know, if you want to show me ones that I have missed, that speak to the specific issues of science, there are a very limited number of studies.

And the issue of whether there is a biologic etiology of this disorder, that is definitely not known. It has not been demonstrated.

Q In his report, Dr. Bockting cites a 1998 study by Pfaefflin, P-F-A-E-F-F-L-I-N, and Junge?

A Yes.

Q J-U-N-G-E, called; "Sex Reassignment, Thirty Years of International Follow-Up Studies

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after Sex Reassignment Surgery --

A Yes.

Q -- a Comprehensive Review, 1961 to 1999. Are you familiar with this study?

A Yes. I've read that study.

Q Okay. Did you take this study into account when formulating your opinion about the quality and quantity of science to support the existence of GID?

A Absolutely.

Q Okay. And how did it inform your view?

A Well, it is essentially a mega study. What they did is they looked at a bunch of studies. They brought them all together. And they manipulated the statistics to come up with an overall satisfaction rate, essentially. And that got expressed as a number somewhere. You know, eighty-seven percent satisfaction. But that's not science.

That is -- those are multiple case reviews that have no controls. There are no controls in any of those studies. And there

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is -- I think that any serious scientists would say that there is a high probability of significant sampling bias. Now, the study is what it is. And it is -- it does -- it does have some value.

But in terms of grading scientific studies, the value of the evidence, it's still down here. It's not an A, B, or a C study.

Q Okay.

A Okay?

Q Do you --

A Now, in the absence of lots of other things, it certainly is helpful. But it certainly isn't great science.

Q Do you disagree that Gender Identity Disorder is a bona fide psychopathologic disorder?

A I'm on the fence at the moment. It's another one of the -- this kind of work has really pushed me hard, intellectually. And it's helping me refine some of my thinking. And I think there are many problems with the diagnosis.

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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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a GID, in your report, in paragraph six or answer number six, you note that researchers are split into many camps. And that some believe there will ultimately be discovered genetic hormonal neurophysiologic causes of Gender Identity Disorder. And others believe that there are multiple psychologic factors, child rearing practices, and are sexually motivating factors at play, in the development of GID.

Do you have an opinion about which of these hypothesis, regarding the etiology of GID, is or are more likely to be either proven or deemed sufficiently established as opposed to others?

A I think the only way any progress is going to be made, into answering that question, is by people starting to find a way to segment the population, in studying these segmented groups.

You know, I'll make it a -- people who transition so that they can be he-shes, in order to prostitute themselves, are totally different,

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in every respect, from the bulk of women who transition to males. The aging transvestites are a totally different group compared to people who come into GID early in their -- you know, into their adolescents or into their early adulthood.

Individuals, who want to transition because they are autogynephillic, both -- I mean, Blanchard's work. They actually have a paraphilia. And they get off by, initially, visualizing themselves as a female, and then get surgeries and the hormones in order to actually act that out. You ever see, "The Silence of the Lambs"?

Q Yes. I have.

A All right. Classic example of an autogynephillic, you know, trans -- probably transgendered individual. The killer. And you -- you know, there are so many different -- there is so many clinical variance that, until we find a way to start studying the variance, that we are going to unravel any of this.

So, there may be one group, in which

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biology plays a key role. But, in another group, it's child rearing practices. Or, in another group, it's the paraphilia. I mean, you couldn't think of more -- three distinct processes. So -- and nothing is going to move ahead if everybody gets lumped into the same group, GID, and the same theories are applied across the board to all GID, irrespective of their stories, their backgrounds, their personalities. It ain't going to happen.

What happens, when you do that, is like when you give psychological studies to a group of -- any kind of group, and it's very disparate, everything mushes out. You get no findings until you segment the group into groups -- until you create distinct groups. That's when we are going to be able to make headway. And it isn't going to happen until we do that.

Q Do you have an opinion about which of these theories you suspect is more likely to bear fruit or be proven, assuming research can be done?

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A I'm more of a clinician. I don't -- I'm not going to -- I can't pass myself off as a -- I'm certainly not a basic scientist. You know, it's unlikely that I am going to answer those questions. I think I know what direction somebody -- I hope we can get some young people to get interested in the science and do this work.

Because I think that's where the answers are. And, as I said, I suspect that it's going to be -- you know, the etiology is going to be different for different segments of the patient pool. I don't think we are going to find a silver bullet that explains this incredibly heterogenous pool.

Q And is that because you think Gender Identity Disorder, the diagnosis simply covers too many different types of people?

A Well, you are characterizing it. I'm saying that the fact is that it's quite heterogenous. But I would not use the word too many.

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A Yes.
Q Okay.
A It's never been replicated.
Q And --
A I mean, you -- I hope you -- well, that finding would be of incredible importance, but there has been no replication.
Q Are you aware of attempts to replicate the study being unsuccessful?
A I believe so. Yeah.
Q Okay.
A I think that is such an important finding, that it has to be replicated. Unless it's replicated, it's not going to be -- it's not going to have much impact.
Q Okay. Are you aware of how many attempts have been made to replicate the study?
A No.
Q Okay. At that point in his report, Dr. Bockting also cites to a 1995 study, by Swaab and Hofman, called; "Sexual Differentiation of the Human Hypothalamus in Relation to Gender and

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Sexual Identity".
Are you familiar with this study?
A I'm sorry, which one is that one?
Q Sorry, Swaab and Hofman report, he cites in his supplemental report. It's a 1995 study called -- he cites the study in paragraph four of his supplemental report, and then lists the title of the article on page four in his list of references.
The article is called "Sexual Differentiation of the Human Hypothalamus in Relation to Gender and Sexual Orientation".
Are you familiar with this study?
A No.
Q And Dr. Bockting also, in paragraph four, cites a 1995 study by Zhou, Hofman, Gooren and Swaab, called; "A Sex Difference in the Human Brain and its Relation to Transsexuality".
And are you familiar with this study?
A Yes.
Q Okay. Is it a -- are the findings in the study findings that you found credible?

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A They are credible, but the inferences I don't think are.
Q And -- and I'm sorry, by inferences, what do you mean?
A That there is a direct relationship between the findings and transsexuality.
Q Okay.
A It's inferred. It's not -- I don't really think that there is -- that it's any kind of conclusive proof for the relationship.
Q Does that study, in your view, warrant further research about whether there might be any relationship between the brain and transsexuality?
A Of course. Yes.
Q Okay. With respect to these three reports -- I think two of them that you said you were familiar with -- did these studies inform your opinion about what the research suggests regarding the etiology of Gender Identity Disorder?
A It suggests the direction of the

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research. But it certainly doesn't suggest that there is a scientifically supported basis for GID.
Q Okay. And so, the question is one that is still open and needs more research.
Is that your view?
A Yeah. Yes.
Q In your report, at question nine, you asked; is the term sex synonymous with the term GID. Obviously your answer is there. I just want to ask you if there is anything else that you would like to offer, as your opinion, on that topic?
A No. I think it's as I said it.
Q Okay. With respect to question ten, question ten is; does sex reassignment surgery change a person's biologic sex. And other than what we have discussed today, do you have anything else that is part of your opinion with respect to that question?
A No.
Q Okay.

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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 translocations, 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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XXY, or XXXY.
And I think some of those conditions also have genetic changes on the chromosomes themselves, or the presence of the extra chromosomes can create intersex conditions or lead to intersex conditions.
Q Okay. And so ambiguous genitalia always indicates some chromosomal abnormality? Is that right?
A I believe so. Yeah.
Q Okay. On page six of your report, you state that sex and sexual identity are not the same. Are there any other bases for your opinion that sex and sexual identity are not the same, other than what is discussed in your report and what we have discussed today?
A I don't think so.
Q Okay. And on page six of your report, you state that:
There is no scientific evidence, to date, to support the contention that transsexuals are on a continuum of sexual identity determined

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by fetal brain exposure to varying amounts of testosterone.
Are there any other bases for this opinion, other than what is listed in your report and what we have discussed today?
A No.
Q And am I right, you have never met the plaintiff in this case?
A I have not.
Q Okay. Are you offering any opinion regarding the plaintiff's specific health condition in this case?
A No. No.
Q So, I believe we discussed, this morning, the questions that you address in your report are questions that were provided to you by the government.
Is that correct?
A That's correct.
Q And I'm going to show you what we will mark exhibit thirty-eight.
(Exhibit Number 38

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was marked for identification.)
BY MS. McGOWAN:
Q I'm showing you a document that the government brought today to your deposition. Do you recognize that document?
A I do.
Q Okay. And what is it?
A It's a document from Ms. Russell to me, about this case, and a list of questions that, as you say, were generated by the government.
Q Okay. Did you have any conversation, with the government, with respect to how to formulate any of these questions?
A With regard -- no. I did not.
Q Okay. And I will show you a document which we will mark thirty-nine.
(Exhibit Number 39 was marked for identification.)
BY MS. McGOWAN:
Q Do you recognize that document?

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A Yes. It seems to me pretty much similar to this document, thirty-eight.
Q And thirty-nine are similar? Is that what you are saying?
A Yes.
Q Okay. And that --
A One is -- the difference is one was sent on the 30th, and one on the 13th of November. October 30th and November 13th.
Q Okay. And with respect to document thirty-nine, that is actually a three page document?
A Um-hum.
Q And the second and third page of the document, what is that?
A Those are my answers. Those are my answers to the questions.
Q And did your answers change, at all, from the draft, that you are looking at now, and what you ultimately put in your final report?
A I don't know. I have to do a side by side and take a look.