NO. DF-10-16083

IN THE MATTER OF	§	**IN THE DISTRICT COURT**
THE MARRIAGE OF	§	
REBECCA LOUISE ROBERTSON	§	**255TH JUDICIAL DISTRICT**
AND	§	
JAMES ALLAN SCOTT	§	**DALLAS COUNTY, TEXAS**

RESPONDENT'S AMENDED REPLY TO PETITIONER'S MOTION FOR SUMMARY JUDGMENT AND BRIEF IN SUPPORT

Pursuant to Texas Rules of Civil Procedure 166a(c), Respondent James Allan Scott, (herein "respondent" or "Mr. Scott") presents this Response to Petitioner's Motion for Summary Judgment and Brief in Support, and respectfully shows the following:

A. PROCEDURAL BACKGROUND

1. In a traditional Motion for Summary Judgment, the movant has the burden of showing that there is no genuine issue of material fact and that it is entitled to judgment as a matter of law. *MMP, Ltd. v. Jones*, 710 S.W.2d 59, 60 (Tex. 1986). In deciding whether there is a disputed material fact issue precluding summary judgment, any evidence favorable to the non-movant must be taken as true. *Nixon v. Mr. Property Mgmt. Co.*, 690 S.W.2d 546, 548-49 (Tex. 1985). Every reasonable inference must be indulged in favor of the non-movant and any doubt resolved in its favor. *Id.* A trial court cannot grant summary judgment for the movant when the evidence does not conclusively prove each and every element of movant's cause of action or negate each element of the non-movant's defense or counterclaims. *MMP, Ltd. v. Jones*, 710 S.W.2d 59, 60 (Tex. 1986).

2. A trial court cannot grant a no-evidence summary judgment motion if the non-movant produces more than a scintilla of evidence raising a genuine issue of material fact on any challenged element. Tex. R. Civ. P. 166a(i).

B. INTRODUCTION AND FACT SUMMARY

1. James Allan Scott (herein "Respondent," "Non-Movant," or "Mr. Scott") and Rebecca Louise Robertson (herein "Petitioner," "Movant," or "Ms. Robertson") obtained a marriage certificate in Dallas County, Texas, on December 16, 1998, after presenting the clerk legally required documents showing proof of age and identity. On December 20, 1998, they were married under Texas law in a traditional wedding ceremony at Bethany Presbyterian Church in Dallas. Respondent and Petitioner have been married and held themselves out as husband and wife for more than 12 years.

2. Petitioner is now attempting to have their marriage declared void through a Motion for Summary Judgment. Petitioner claims that, because her husband is a transsexual man, she is the same sex as her husband. Further, because Texas law bans same-sex marriage, Petitioner claims their twelve-year marriage never existed and she is entitled to prevail on her Motion as a matter of law.

3. However, no such mandatory controlling legal authority exists over this court that would nullify their marriage and support this motion for summary judgment. To the contrary, mandatory legal authority now exists in Texas that fully upholds the validity of the marriage between Petitioner and Respondent. The court should find that Respondent James Allan Scott is a man for the purpose of marriage and that this marriage is valid, deny Petitioner's Motion for Summary Judgment, and allow this case to proceed as a divorce action.

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CONSTITUTIONS

United States Constitution

U.S. Const. amend. XIV, § 1.

U.S. Const. art. IV, § 1.

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Tex. Const. art. I, § 32

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In the Matter of the Marriage of J.B. and H.B., 326 S.W.3d 654 (Tex.App.—Dallas 2010).

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Randle v. NCNB Texas Nat'l Bank, 812 S.W.2d 381 (Tex.App.--Dallas 1991, no writ).

Schacht v. Schacht, 435 S.W.2d 197 (Tex.App.—Dallas 1968).

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In re Dickerson, 1978 WL 891 (Penn. 1978).

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Texas

Tex. Fam. Code § 1.101 (Vernon's 1997).

Tex. Fam. Code § 2.001(b) (Vernon's 2009).

Tex. Fam. Code § 2.005(a) (Vernon's 2009).

Tex. Fam. Code § 2.005(b)(8) (Vernon's 2009).

Tex. Fam. Code § 2.301 (Vernon's 1997).

Tex. Fam. Code § 2.401 (Vernon's 1997).

Tex. Fam. Code § 6.106 (Vernon's 1997).

Tex. Fam. Code § 6.204 (Vernon's 2009).

Tex. Health and Safety Code Ann. § 191.028 (Vernon's 2009).

Tex. Health and Safety Code Ann. § 192.011 (Vernon's 2009).

Tex. R. Civ. P. 166a(c).

Tex. R. Civ. P. 166a(i).

Other States

2011 N.Y. Laws A8354-2011.

Iowa Code § 144.23 (2009).

SECONDARY SOURCES

Aetna Clinical Bulletin: Gender Reassignment Surgery. Bulletin Number 0615. http://www.aetna.com/cpb/medical/data/600_699/0615.html. Accessed on: October 3, 2011.

World Professional Association for Transgender Health, Harry Benjamin International Gender Dysphoria Association, *The Standards of Care for Gender Identity Disorders, Sixth Version* (February 2001), http://www.wpath.org/publications_standards.cfm. Accessed on: September 17, 2011.

EVIDENCE / EXHIBITS

A) Aetna Clinical Bulletin: Gender Reassignment Surgery. Bulletin Number 0615. http://www.aetna.com/cpb/medical/data/600_699/0615.html. Accessed on: October 3, 2011.

B) World Professional Association for Transgender Health, Harry Benjamin International Gender Dysphoria Association, *The Standards of Care for Gender Identity Disorders, Sixth Version* (February 2001), http://www.wpath.org/publications_standards.cfm. Accessed on: September 17, 2011.

C) Affidavit of Eric Gormly (attesting to the authenticity of Exhibits A & B as exist on their respective websites).

D) Affidavit of Collier M. Cole, Ph.D.

E) Curriculum Vitae of Collier M. Cole, Ph.D.

F) Affidavit of James Allan Scott – Life Statement (include items noted, plus names of all health care professionals)

G) Affidavit of Dr. Jaime Vasquez, D.O., P.A. (Director, Vasquez Family Clinic), and Documents Verifying WPATH Transsexual Transition Standards of Care fully met for James Allan Scott.

H) Order handed down by 134th District Court of Dallas County, Texas (certified copy filed with clerk of the 255th Family District Court of Dallas County, Texas).

I) Iowa Code § 144.23 – "State Registrar To Issue New Certificate"

J) Birth Certificate – James Allan Scott (certified copy filed with clerk of the 255th Family District Court of Dallas County, Texas).

K) Marriage License – James Allan Scott & Rebecca Louis Robertson (original filed with clerk of the 255th Family District Court of Dallas County, Texas).

L) Affidavit of Jean Martin, professional tax preparer for James Allan Scott & Rebecca Louis Robertson.

M) IRS Form 1040 for years 2004, 2007, 2010 – James Allan Scott & Rebecca Louis Robertson.

N) Affidavit of James Allan Scott (attesting to the authenticity of Exhibits H, J, K and M).

ARGUMENTS AND AUTHORITIES

C. PETITIONER AND RESPONDENT ARE LEGALLY MARRIED UNDER THE LAWS OF TEXAS

1. Petitioner Rebecca Louise Robertson maintains that her twelve-year marriage to Respondent James Allan Scott is void because he is a transsexual man and she is a genetic woman. Petitioner claims that this constitutes a same-sex marriage and thus is a nullity *ab initio*.

2. Petitioner cites the Texas Family Code, the Texas Constitution and the Federal Defense of Marriage Act to support her position that same-sex marriages are void in Texas. Tex. Const. art. I, § 32. Tex. Fam. Code §§ 2.001(b) & §6.204. Mr. Scott acknowledges that this accurately states existing law in Texas, but asserts that the ban on same-sex marriage in Texas is irrelevant. James Allan Scott is not a woman, he is a transsexual man. Further, he holds a birth certificate issued by the state of Iowa that shows his sex to be male, evidence the Petitioner/Movant cannot dispute or rebut. Thus the law banning same-sex marriage in Texas does not apply.

3. Petitioner can cite no statute or clear test of what defines a woman or a man for the purpose of marriage, because no such definition or provision exists, either in the state constitution or any of Texas's statutes. Instead, Petitioner relies heavily on a 1999 split decision from the San Antonio Court of Appeals, *Littleton v. Prange*, 9 S.W.3d 223 (Tex.App.—San Antonio 1999, pet. denied) .

4. This is a case of first impression for this venue. This brief will address *Littleton* and other case law in more detail infra, but at this point, it is important to point out that there is no settled law on this issue. When Ms. Littleton appealed the decision to the Texas Supreme Court, the high court did not refuse petition, it denied petition. The difference is significant, for it means the decision was then and is still controlling for no court in the state save those under the 4th Appellate District, which sits in San Antonio. As such, the 1999 *Littleton* decision carries only persuasive authority in this court. Even at that, much has emerged in the intervening years to bring both the legitimacy and the wisdom of that decision into doubt.

5. Most significantly, *Littleton* has been overturned in this state by operation of law through a 2009 amendment to the Texas Family Code. Tex. Fam. Code § 2.005(b)(8) (Vernon's 2009). This brief will address this in detail infra.

D. TEXAS LAW HOLDS A STRONG PRESUMPTION THAT A MARRIAGE IS VALID

1. In Texas, the Family Code clearly asserts that it is the strong public policy of the state to maintain a presumption that a marriage is valid, absent a strong reason to find the marriage is void or voidable:

> "[I]n order to provide stability for those entering into the marriage in good faith...it is the policy of this state to preserve and uphold each marriage against claims of invalidity unless a strong reason exists for holding the marriage void or voidable." Tex. Fam. Code § 1.101 (Vernon's 1997).

2. In fact, barring that one of the parties has provided false answers on the marriage application, that marriage is valid, even despite fraud, mistake, or illegality in obtaining the license. Tex. Fam. Code §2.301 (Vernon's 1997). Thus, the law places an extraordinarily high burden to overcome for anyone challenging the validity of an established marriage. The courts historically and consistently have upheld this presumption:

> "One of the strongest presumptions of law is that a marriage, once being shown, is valid." *Schacht v. Schacht*, 435 S.W.2d 197, 201 (Tex.App.—Dallas 1968).

> "The presumption is, in itself, evidence, and may even outweigh positive evidence to the contrary." *Texas Emp. Ins. Ass'n v. Elder*, 282 S.W.2d 371, 373 (Tex. 1955).

3. The evidence to overcome a legal presumption must be clear and compelling, and a court typically must rely on a legal test to come to a conclusion.

E. NO TEST EXISTS TO DETERMINE WHO IS A MAN OR A WOMAN FOR THE PURPOSE OF MARRIAGE

1. In the present case, the court must address the issue of how to establish or define whether someone is male or female, or what constitutes being a woman or a man. However, there exists no clear test, legislative or otherwise, of how to make a legal determination of a person's sex for the purpose of marriage. A court from another jurisdiction summarized this very issue by holding that, absent a clear, scientifically based and legally supportable test, it would be a mistake to "broadly conclud[e], apparently as a matter of law, that gender [is] not subject to modification or adjustment." *In re Heilig*, 816 A.2d 68, 87 (Md. 2003).

2. It would be contrary to the marital presumption, and thus the strong public policy of Texas, to allow a broad conclusion based on a lack of knowledge, a misunderstanding of the evidence, or a dubious legal argument, to overcome a long-standing marriage. Further, with no clear-cut test, there can be no clear and compelling proof presented to overcome the presumption. Absent such clear and compelling proof, no court is justified in ruling against such a strong legal presumption.

3. Unless this court and the 5th Court of Appeals both hold that Petitioner has overcome that high burden of legal presumption by showing through clear and compelling proof that Mr. Scott is not a man but a woman, the court is obligated to uphold the legitimacy of the marriage between Ms. Robertson and Mr. Scott.

F. *LITTLETON v. PRANGE* – NOT SETTLED LAW, NOT CONTROLLING AUTHORITY, AND DISTINGUISHABLE FROM THE PRESENT CASE

1. Petitioner claims her twelve-year marriage is void as a matter of law, basing her claim on the position that a transsexual man married to a woman constitutes a same-sex marriage. Because there is no statutory definition of "woman" or "man," Petitioner has failed to meet her statutory burden of proof and thus cannot prevail on summary judgment via that path.

2. To support her argument, Petitioner relies primarily on one decision, *Littleton v. Prange*, which is not settled law and carries no authoritative weight in Dallas or any other county under the Fifth Court of Appeals District. *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App.—San Antonio 1999, pet. denied).[1] In her brief, Petitioner asserts that the Littleton decision defines man and woman. It absolutely does not, by Justice Hardberger's own words: "We cannot make law when no law exists; we can only interpret the written word of our sister branch of government, the legislature." *Littleton*, 9 S.W.3d at 230. Each of the three justices in *Littleton* wrote a separate opinion based on different reasoning. Each of the three also acknowledged both an absence and a need for legislative guidelines in determining recognition of marriages involving transsexuals. *See Id.* at 230-32.

[1] Christie Lee Littleton had sued a surgeon in a wrongful death and medical malpractice suit following the death of her husband. The surgeon and his insurance company discovered that Ms. Littleton was a transsexual woman, based on differences found on her original birth certificate. They moved for summary judgment based on standing, claiming that Ms. Littleton was not a woman, and because she was a man, no marriage had existed, thus she had no standing to sue on behalf of her deceased husband. The court held for the doctor and his insurance company, the widow appealed, and the San Antonio Court of Appeals upheld the trial court's decision.

3. Justice Hardberger asserted that, because Ms. Littleton had what appeared to be male genitals when she was born, she must have male genes and therefore be male. *Littleton*, 9 S.W.3d at 231. He conceded that Ms. Littleton had an amended birth certificate, *id.*, which Texas law permits if needed "to complete or correct a record that is incomplete or proved by satisfactory evidence to be inaccurate." Tex. Health & Safety Code Ann. § 191.028 (Vernon's 2009).[2] However, Justice Hardberger determined that the statute applied only to inaccuracies existing at the time of birth, not those that might arise after birth. *Littleton*, 9 S.W.3d at 231.

[2] This portion of the statute read the same in 1999.

4. The problem in Justice Hardberger's reasoning is two-fold. First, section 192.011 of the Health and Safety Code applies to "an amending birth certificate that is filed under Section 191.028 and that completes or corrects information relating to the person's sex, color, or race," Tex. Health & Safety Code § 192.011 (a), which the clerk is required to either replace or issue anew if requested to do so. *Id.* § 192.011 (b). This is commonly the situation with an adopted child whose parents can request a new birth certificate – a document that necessarily will show changes after the time of birth. Second, prior to 2009, Section 2.005 of the Family Code authorized county clerks issuing marriage licenses to accept "a certified copy of the applicant's birth certificate or . . . some certificate, license, or document issued by this state or another state, the United States, or a foreign government," as proof of identity and age. A driver's license qualifies, is commonly used for such purposes, and is accepted just as readily as a birth certificate. Furthermore, a driver's license must be updated to reflect changes that regularly occur in a person's life well after the time of birth, such as address, hair color, height, and so on.

5. Justice Angelini concurred with Justice Hardberger in judgment only. Justice Angelini's opinion expressed grave concerns over Justice Hardberger's exclusive reliance on external appearance and dismissal of any psychological factors. *Id.* at 232. She went on to correctly point out that there exists many variations in chromosomes, some are born with ambiguous genitalia, and some are born with both genitalia. *Id.* at 232. Given this reality and setting aside the psychological aspects of gender identity, such a simplistic pronouncement on what is male or female guarantees that some infants will be assigned the wrong gender for purely physiological reasons alone. *Id.* at 232.

6. Justice Lopez issued a strong dissent, ultimately holding that a fact issue existed in the case, which meant the court could not and should not have granted summary judgment. *Id.* at 231. One key point revolved around the defendant producing one piece of evidence only, which was Ms. Littleton's original birth certificate showing "male" as the sex designation. *Id.* at 232. When Ms. Littleton presented controverting evidence to show she was female, she created a genuine issue of fact, which should have precluded summary judgment. *Id.* at 232. Justice Lopez declared that the absence of law meant there was no legal basis to support the conclusion reached by justices Hardberger and Angelini. *Id.* at 232.

7. Beyond this issue, Justice Lopez states that Texas law recognizes inaccuracies in determining or recording gender, and states that Ms. Littleton corrected her birth certificate prior to the trial court's ruling on defendant's motion for summary judgment. *Id.* at 232. Furthermore, Justice Lopez makes a compelling argument in maintaining that an amended document effectively nullifies the original and takes its place:

> "Under the rules of civil procedure, a document that has been replaced by an amended document is considered a nullity. Rule 65 provides that the substituted instrument takes the place of the original. TEX.R. CIV. P. 65. Although neither a state statute nor case law address the specific effect of an amended birth certificate, many cases address the effect of an amended pleading. See *Randle v. NCNB Texas Nat'l Bank*, 812 S.W.2d 381, 384 (Tex.App.--Dallas 1991, no writ) (striking of second amended pleading restored first amended pleading); *Wu v. Walnut Equip. Leasing Co.*, 909 S.W.2d 273, 278 (Tex.App.--Houston [14th Dist.] 1995) (unless substituted instrument is set aside, the instrument for which it is substituted is no longer considered part of the pleading), rev'd on other grounds, 920 S.W.2d 285 (Tex.1996). Under this authority, an amended instrument changes the original and is substituted for the original. Although a birth certificate is not a legal pleading, the document is an official state document. Amendment of the state document is certainly analogous to an amended legal pleading." *Id.* at 232.

8. Based on the flaws in Justice Hardberger's reasoning regarding statutory construction and application of law, the concerns expressed by Justice Angelini, and the strength of Justice Lopez' dissent, one has grounds, based on statutory construction and legal interpretation, to assert that the *Littleton* decision now should be questioned. Paraphrasing the position of Justice Hardberger quoted supra, to effectively create law on the bench while lacking a clear test or

statutory guidelines, especially when the decision defies a strong legal presumption, could be considered judicial activism.

9. *Littleton* carries no precedential weight in Dallas County. The decision is not now, nor has it ever been, mandatory authority for the Dallas District courts. Dallas County is bound by decisions handed down by the United States Supreme Court, Texas Supreme Court, the Texas Court of Criminal Appeals, and the Fifth Court of Appeals. Even within a given appellate district in this state, one three-justice panel may hold one way on an issue, and a different three-justice panel on the same court of appeals may decide another way, requiring an en banc decision to resolve the conflict. However, it is critical to recognize that, with no other considerations, the Littleton decision would bear only persuasive authority in this court, and the flaws in the decision should lessen its weight even further.

10. *Littleton's* subsequent history implies our state's high court also saw flaws in the opinion. When Ms. Littleton appealed the decision to the Texas Supreme Court, the Court reviewed the petition and refused to hearing the case, with the notation, "petition denied." Had the notation been "petition refused," *Littleton* would carry authority with the same weight of a supreme court decision in this state. In stark contrast, the subsequent history "petition denied" designates a case in which the Court is not satisfied that the opinion of the court of appeals has correctly declared the law in all respects, but believes that the petition either presents no error of the sort that the law requires to be reversed, or presents no error of such importance to the jurisprudence of the state that the decision requires correction. See Tex. R. App. P. 56.1(b)(1). Put another way, the high court believed the Littleton decision failed to correctly declare the law in one or more respects, but whatever error existed was either not the sort that required the Court to reverse it, or not deemed to be critical to the integrity of Texas jurisprudence.

11. As stated supra, there is no settled law on this issue. Contrary to the position taken Petitioner and Movant in the present case, the absence of statutory law does not equate to the existence of a pure question of law.

12. Legal and factual distinctions make *Littleton* distinguishable from the present case. First, the key legal issue centered on whether Ms. Littleton had standing to sue a medical doctor and his insurance company for the wrongful death of her husband. Second, the defendants in that case found a presented the birth certificate purported to have been issued at the time of Ms.

Littleton's birth on which the attending physician had noted her sex as male. This designation was counter to her amended birth certificate, which showed her sex as being female.

13. In the present case, Mr. Scott's standing is not at issue in this motion for summary judgment. More importantly, Mr. Scott possesses, not an amended birth certificate, but a birth certificate, issued by the state of Iowa, that shows his sex as male. Furthermore, the Petitioner/Movant cannot present an original birth certificate to rebut this evidence because the only birth certificate held by the Iowa Bureau of Health Statistics – the original birth certificate – shows Mr. Scott to be male.

G. THE MARRIAGE BETWEEN JAMES ALLAN SCOTT AND REBECCA LOUISE ROBERTSON IS NOT A SAME-SEX MARRIAGE: GENDER IDENTITY DISORDER AND TRANSSEXUALISM DESCRIBED

1. Petitioner maintains that the marriage between Ms. Robertson and Mr. Scott is void because it is a same-sex marriage. This claim fails to recognize transsexualism for what it is. Indeed, the overwhelming weight of scientific and behavioral evidence indicates it is patently false to claim that a transsexual man is actually a woman, or that a transsexual woman is actually a man.[1]

[1] The extant research legitimizing this condition is grown to the point that many health insurance companies recognize it, cover it, and require the Benjamin Standards of Care and evaluation criteria as a prerequisite to coverage. For example, Aetna publishes a clinical policy bulletin specifying its criteria for gender reassignment surgery and enumerating its CPT and ICD-9 codes for procedures covered in treating a transsexual, including gender reassignment surgery. It bases its coverage on 33 listed references, including the Harry Benjamin International Gender Dysphoria Association and a journal article authored by Dr. Collier Cole. Aetna Clinical Bulletin: Gender Reassignment Surgery. Bulletin Number 0615. http://www.aetna.com/cpb/medical/data/600_699/0615.html. Accessed on: October 3, 2011. Exhibits A and C.

2. The many medical and research organizations that have conducted or compiled research into Gender Identity Disorder include, but are not limited to, the American Association of Sex Educators, Counselors, and Therapists; the American Psychological Association; the Texas Psychological Association; and the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association. Exhibits B and C.

3. WPATH has long-established and internationally accepted Standards of Care (SOC) for the treatment of gender identity disorders. These are recognized and accepted by a number of psychological and medical entities, including the American Medical Association, the Texas

Department of Health, and the Endocrine Society of the U.S. In addition, the Standards of Care have been updated and revised as new scientific information becomes available, and is currently in its sixth edition. Harry Benjamin International Gender Dysphoria Association's The Standards of Care for Gender Identity Disorders, Sixth Version (SOC), February 2001, http://www.wpath.org/publications_standards.cfm. Exhibit B.

3. A leading expert in Gender Identity Disorder is Collier M. Cole, Ph.D., a licensed clinical psychologist in the state of Texas, and a Clinical Full Professor in the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch, Galveston. Dr. Cole's sworn statement and curriculum vitae are attached to this brief as Exhibits D and E. Dr. Cole's affidavit supports the text of sections G and H of this brief.

4. Gender identity, according to Dr. Cole, is the personal private sense of being male or female. This usually but not always conforms to the genitals and other physical traits the person has. However, sexuality is complex, and is more a function of the brain than the genitals. In the case of someone with the condition known as Gender Identity Disorder (GID), formerly referred to as Gender Dysphoria, the person has longstanding and persistent feelings of being a member of the opposite sex, feelings that typically begin in early childhood. These feelings can and typically do lead to intense psychological conflict. This conflict results from the conviction that the person is one sex, but the person's body is the other. Without treatment as prescribed by the Standards of Care, this person will suffer intense psychological distress throughout life.

5. Research increasingly suggests that biological factors are behind GID, and recent scientific studies indicate that gender dysphoria may be related to a neuro-endocrine difference in the person's brain prior to birth, which can be distinct from genetics or anatomy. Sexuality is complex, involving chromosomes, hormones, sexual anatomy, gender identity, sexual orientation, and sexual expression, among other underlying factors. All of these need to be taken into account, rather than simply relying on the male or female designation an attending physician or nurse makes during a quick exam of the infant's genitals – which may be mistaken. Sex is determined, not by what's between the legs, but by what's between the ears.

6. In 1980, the Harry Benjamin International Gender Dysphoria Association established the first so-called Standards of Care. See Exhibit B. The person with GID must undergo extensive psychological evaluation and therapy. The central method used to confirm a diagnosis of gender dysphoria consists of the "real life experience." Lasting a minimum of a year, the

person undergoes hormone therapy to become more male or female in appearance, and lives and works fulltime in the adopted gender role. During this time, the therapist works in coordination with the patient's physician. Once the real life experience is complete and the therapist confirms as much, the person can change his or her name, change gender designations on identity documents and so on. Following a successful transition, an individual may pursue gender reassignment surgery to reform the body, including reconstructing the genitals, to appear more like the person perception of self.

7. There also are certain conditions stemming from chromosomal anomalies, such as XXY, 46XY, 46XX, or 47XY chromosome sequences. Also, anatomical anomalies, such as intersex conditions, are not uncommon. In these cases, physicians are urged not intervene until the person old enough to accept his or her gender identity. As with gender dysphoria, the person can undergo surgical and medical procedures to line up that person's body to fit the mind. This completes the treatment and resolves the underlying issue.

8. Dr. Cole maintains there is no "cure" for this condition, and he sees the fact that the physical apparent sex fails to match the psychological sex as a sort of birth defect. The treatment is to counsel the person on how to adjust, prescribe hormone therapy, and have them carry out the "real life experience." During this period, through continued counseling, the therapist and physicians can determine if the person is an appropriate candidate for fulltime living in the chosen gender and for sexual reassignment surgery.

9. In addition to psychological distinctions, research indicates that the physical brain of a transsexual may be different and function differently from the typical brain of someone with a gender identity that conforms to that person's general physical traits. Many aspects of sexuality exist more in the grey matter than in the anatomical parts that typically distinguish male from female. Transsexualism as an intense discomfort with one's gender assignment as designated at birth, leading to an intense conflict the person experiences from his or her psychological sex not matching the body he or she inhabits. This is not a choice, and there is no "cure" for Gender Identity Disorder. The treatment is working with the patient to bring his or her body more in line with his or her brain. The process of evaluating GID and monitoring the regimen involved in a transsexual's transition is a painstaking, exacting and irreversible one, lasting anywhere from one to two years.

10. There is a clear and definite distinction between transsexualism and homosexuality. Transsexuality applies to the feeling that someone has about him or herself, such as, "Am I comfortable being a man," or "Do I feel like a woman even though I have a male body?" Sexual orientation – heterosexuality, bisexuality or homosexuality – refers to who a person is attracted to: men, women or both. Sexual orientation refers to relationships with others. Gender identity refers to the relationship with one's self.

11. Sexual orientation is separate from gender identity, and typically does not change following transition. Once the person completes the reassignment from female to male, that transsexual man who is attracted to women should be considered heterosexual. Furthermore, that person is highly unlikely to have considered himself a lesbian prior to transition.

12. The sexual reassignment surgery is extensive and irreversible. For the female to male transsexual, following the year-long "real life experience," the patient goes through surgery to remove the uterus, ovaries, and fallopian tubes, known as "bottom surgery," and to remove the breasts, known as "top surgery."

13. A procedure called phalloplasty, which is the creating of an appendage meant to resemble a male penis, is one option a transsexual man can have performed. However, many medical and psychological professionals recommend against it, and many patients go with other options. The phalloplasty technique takes muscle tissue from the arm or other part of the body, then attempts to form the tissue into a tube-shaped appendage that is surgically attached to the pubic area. Complications with this procedure include leaving a deformity where the tissue is taken, a scar, a long and painful recovery, risk of infection, and risk of loss of the limb's full function. An additional complication is that the appendage does not fully look like a penis, does not function like one in terms of sexual activity (it requires an implant to achieve an erection), and largely lacks sensation. Further complications can include urinary tract infections, urinary tract obstructions, risk of renal failure, or the need to wear a Foley catheter. In a common complication, sections of the phallus tissue itself can die and slough off or need to be surgically removed. Finally, the surgery is extremely expensive.

14. However, a clitoris is actually quite similar in structure to the penis. Just as testes and ovaries begin as the same group of cells in a developing fetus, so do the penis and the clitoris. After extended exposure to testosterone during transition, the clitoris will begin to enlarge until it reaches and maintains the size and appearance of a small penis. Furthermore, the clitoris contains

the same sort of tissues as the penis, and thus will respond to sexual stimulation as the penis does by swelling, extending and becoming erect. As a result, many female to male transsexuals decide against a phalloplasty, instead allowing the clitoris to develop from the testosterone.

15. With the clitoris permanently enlarged on testosterone, transsexual men can later opt for a procedure known as metoidioplasty, also known as a "clitoral release." Compared to a phalloplasty, this is a relatively simple, low-cost and low-risk surgery that enables the newly developed "penis" to extend farther.

16. But therapists who work with transgendered clients consider neither a phalloplasty nor a metoidioplasty necessary to achieve "completion" of the transition for a female to male transsexual. Rather, after completing the "real life experience," completing the psychological therapy and hormone therapy, and undergoing surgeries to remove the breasts, ovaries, fallopian tubes and uterus, that person is considered a fully transitioned transsexual man.

H. JAMES ALLAN SCOTT IS AND SHOULD BE RECOGNIZED AS A MAN FOR ALL LEGAL PURPOSES

1. In Mr. Scott's case, at a young age, he experienced the same feelings of being the opposite sex of the gender he had been assigned at birth, feelings that continued and strengthened throughout his life. Although born with a female anatomy, Mr. Scott considered himself to be, not a lesbian woman, but a heterosexual man with the wrong body. Exhibit F.

2. Mr. Scott underwent all of the necessary evaluations, which found him to be psychologically male. Exhibits F and G. He underwent the full regimen of procedures in following the Standards of Care as prescribed by WPATH, including long-term therapy, testosterone therapy, and living full time as a man, or the "real life experience." Id. Ultimately, Mr. Scott had irreversible surgeries performed to more fully enable him to live his life as a man. Specifically, the series of surgeries was performed on Mr. Scott to remove his breasts, ovaries, fallopian tubes and uterus. Id. He decided against a phalloplasty, opting instead to pursue a metoidioplasty. Exhibit F.

3. Mr. Scott petitioned Dallas County District Court for a change of name and sex designation, supplying the necessary documents to do so. On March 13, 1998, the court granted an order that his name and gender marker be appropriately changed. Exhibit H. Mr. Scott then presented the full set of documentation required by the state of Iowa for a new birth certificate,

which included verification of evaluation for Gender Identity Disorder, psychological therapy, recommendation to transition, real life experience, hormone therapy, and the irreversible sexual reassignment surgery. Exhibit I. After reviewing the proper documentation, the state of Iowa issued Mr. Scott a new birth certificate. Exhibit J.

4. In light of the previous discussion, Mr. Scott rebuts a number of "facts" the Petitioner asserts in her brief. Female gender is not "universally determined" by looking at genitalia, as stated by Petitioner in Fact 4.B. Indeed, without any legal test for what determine a man or a woman for the purpose of marriage, Petitioner has no grounds to apply her own definition of female or claim a "universally determined" standard in doing so. Facts 4.A. and 4.B. In addition, by asserting that Mr. Scott has failed to complete the medical procedures that "would provide her [sic] with male genitalia," Petitioner shows a lack of understanding of the current state of medical technology relating to sexual reassignment surgery for a female-to-male transsexual. No procedure exists that could do so safely or effectively, and, in fact, would get in the way of sexual function and pose a potentially dangerous health risk.

5. By the same measure, Petitioner has no grounds, as she asserts in Fact 4.E., to determine what are the "universally accepted attributes of a male," nor can she claim that Mr. Scott lacks such characteristics. Petitioner claims these "universally accepted attributes" consist of "a penis, scrotum or testicles." Mr. Scott rejects that statement, as do many health care professionals who deal with sexual issues.

I. THE FALLACY OF "CONSUMMATION" OF MARRIAGE

1. To support her bid to void the marriage, the Petitioner repeatedly has invoked the issue of "consummating" the marriage or failure to do so. Given the context, one must infer she refers to legitimizing the marriage through the sexual act, specifically sexual intercourse, and that the failure to do so somehow results in the marriage being nullified. There are at least five fallacies that emerge from asserting this position.

"Consummation" Not Required For Marriage Legitimacy

2. First, the Texas Family Code does not require "consummating" a marriage. Even a common law, or so-called informal, marriage requires only that the couple agree to be married, that they cohabitate as husband and wife, and they represent to others they are married. Tex.

Fam. Code § 2.401 (Vernon's 1997). Nothing in the Texas statutes requires the husband to sexually penetrate the wife to make the marriage legal. Inter alia, by definition, the Petitioner and Mr. Scott are common law married, which otherwise would be a fact question for a jury to decide, not the court. *Jordan v. Jordan*, 938 S.W.2d 177 (Tex. App. 1997).

Impotency and Nullification

3. Either party may annul the marriage if, at the time of the marriage, the other party was permanently impotent, for physical or mental reasons, and the Petitioner did not know at the time of the marriage. Tex. Fam. Code § 6.106 (Vernon's 1997). In the present case, both parties clearly entered into the marriage willingly and in good faith, with each fully aware of the physical characteristics and sexual responses of the other spouse.

4. Further, even if the Petitioner had not known of Mr. Scott's physical characteristics, that basis for annulment evaporates if the petitioner voluntarily cohabitates with the other party after learning of the "impotency." Id. They cohabitated the same home, slept in the same bed, and held themselves out as husband and wife for 12 years. Whatever sexual intimacy the Petitioner and Mr. Scott shared apparently was satisfactory enough that the Petitioner waited 12 years before attempting to end the marriage by suing to have it declared void.

The State Must Stay Out of the Bedroom

5. Third, the Petitioner seems to imply that the marriage does not legitimately exist unless the erect, male penis of one enters the vagina of the other. Thus, Petitioner is asserting what is and is not the proper, appropriate method for sexual coupling. That position and any cases that support it stand in direct defiance of the landmark decision *Lawrence v. Texas*, in which the U.S. Supreme Court stated that the step cannot prescribe or restrict or criminalize any manner of physical, sexual expression that two consenting adults might choose to engage in. *See Lawrence et al. v. Texas*, 539 U.S. 558 (2003). The Court made it clear that the correct and appropriate manner for two adults to engage in sexual contact is whatever those two adults decide it is. In other words, the Supreme Court told the state to stay out of our bedrooms.

6. Further, this relates to outmoded claims that the purpose of the marriage and of having sex itself is to procreate. As discussed in Lawrence, one of the purposes behind the sodomy laws of Texas was to criminalize sexual activity not oriented toward procreation. This was also one of the two bases for a 1974 New York case the Petitioner cites in support of her action, the other

being the lack of a penis. *Frances B. v. Mark B.*, 355 N.Y.S.2d 712 (N.Y.Sup.Ct. 1974) (holding that either infertility or physical incapacity for a sexual relationship – in this case, a lack of biologically male genitals in the husband – constituted grounds for annulment).

7. The U.S. Supreme Court decision in *Lawrence* overturned sodomy laws as they relate to two consenting adults, holding them to be an unconstitutional interference by the state in the private intimate lives of its citizens. *See Lawrence v. Texas*. As will be discussed infra, New York has effectively overturned *Frances B. v. Mark B.* and other decisions barring transsexuals from marrying by legislating them into irrelevance.

Mr. Scott Possesses the Functioning Anatomy of Other Transsexual Men

8. Fourth, Mr. Scott's change in anatomy is consistent with the change that most transsexual men have experienced. At the risk of being indelicate, Mr. Scott is just as capable of becoming erect and penetrating a woman as a genetic man with a small penis. And in the case of the Petitioner, has done so.

Genetic Men Who Have Lost Function or Lost Their Genitals

9. Many men have suffered testicular cancer, requiring that one or both testes be surgically removed. Although rare, cancer of the penis can also force the removal of some or all of the penis to save the man's life. Many men suffer from significantly low levels of testosterone production and take supplemental testosterone to treat the condition. Spinal cord injuries can diminish or end sexual function in a man, medication for high blood pressure can dramatically decrease a man's sexual functioning, and high levels of stress can diminish the libido, and the list goes on. The Petitioner herself works at a Veteran's Administration hospital, where many war veterans are treated for injuries or conditions suffered while on duty. A significant number of men return from battle with injuries that have damaged or destroyed their genitals, or leave them unable to fully function. One must ask if such a loss of function would not make that individual any less of a man.

10. Ultimately, for the purpose of marriage, the presence of a man's genitals or lack thereof is not dispositive for determining if someone is male.

11. In her brief, Petitioner referred repeatedly to the state constitutional and statutory bans on same-sex marriage and the federal Defense of Marriage Act (DOMA), all of which state that a marriage is valid only if between one man and one woman. These references are

irrelevant. Transsexualism is distinct from homosexuality in the same way that transsexual marriage is distinct from same-sex marriage. This marriage is not a same-sex marriage.

J. NEITHER A LOCAL COURT ORDER NOR AN IOWA BIRTH CERTIFICATE QUALIFY AS "MERELY MINISTERIAL": ENFORCEABLE JUDGMENT AND FULL FAITH & CREDIT

1. Petitioner quotes *Littleton* and several foreign cases to attack the legitimacy of using a birth certificate to show one's sex, claiming that, in many jurisdictions, a court order and change of information on a birth certificate is merely "a ministerial act," thus lacking any legal fact-finding. As such, Petitioner claims Mr. Scott's birth certificate is both unreliable and unworthy of Full Faith and Credit recognition as required under the U.S. Constitution. U.S. Constitution, Article 4, Section 1. The Petitioner's argument falls short on a number of elements, as do a number of facts she cites in an effort to support that argument.

2. First, to correct several misstated facts in Petitioner's brief:

a. Mr. Scott was born in Davenport, Iowa, not Bettendorf. See Exhibit J.

b. Mr. Scott's had his breasts removed in June of 1998; a complete hysterectomy already had been performed prior to 1998. See Exhibit G.

c. Mr. Scott had his petition heard for change of name and gender designation on March 13, 1998, not March 27, 1998, and it was granted by the 134th Judicial District in Dallas County, Texas, not in Iowa. See Exhibit H.

3. Next, Petitioner claims that Iowa's issuance of Mr. Scott's birth certificate was merely ministerial and lacked any fact-finding. If this were true, the birth certificate would not be dispositive and would require fact-finding. Thus, the court should deny Petitioner's Motion for Summary Judgment because issues of fact and not of law are involved.

4. However, in Mr. Scott's case, there are indeed findings of fact required for a new birth certificate to be issued. The Iowa Code § 144.23 states, in pertinent part:

> **144.23 STATE REGISTRAR TO ISSUE NEW CERTIFICATE.**
> The state registrar shall establish a new certificate of birth for a person born in this state, when the state registrar receives the following:
>
> .....

> 3. A notarized affidavit by a licensed physician and surgeon, or osteopathic physician and surgeon, stating that by reason of surgery or other treatment by the licensee, the sex designation of the person has been changed. The state registrar may make a further investigation or require further information necessary to determine whether a sex change has occurred.

5. As discussed supra, prior to applying for his birth certificate, Mr. Scott went through the full Standards of Care protocol, spent a year and a half in therapy, was cleared for the final surgery and change of sex designation by his primary physician, his therapist, and his surgeon. An osteopathic physician in Dallas, Dr. Jaime Vasquez, oversaw the treatment and transition.

6. Mr. Scott then petitioned the 134th Dallas District Court with the required verified documentation, and the court rendered an enforceable judgment in the form of a court order. Thus, a district court in this jurisdiction and this venue issued an enforceable order recognizing Mr. Scott as male.

7. By Iowa statute, the birth certificate required fact-finding and sworn statements by medical and psychological professionals, which Mr. Scott provided. Mr. Scott also provided the court order, to which Iowa was bound to give full faith and credit under the U.S. Constitution. This clearly is not a purely administrative action that would be classified as merely ministerial. If it were, however, that would open a fact question, which would preclude summary judgment as a matter of law.

8. Beyond this point, as opined by Judge Lopez in the *Littleton* dissent, a new birth certificate would supersede the previously issued, and mistaken, document. Failure to recognize this document not only violates the Full Faith and Credit Clause, but it effectively allows a court to pick and choose which court orders and identity documents it wishes to recognize and which not.

9. However, Mr. Scott's Iowa birth certificate was not the result of a merely ministerial act, significant fact-finding was required, and the birth certificate must be accepted for what it is.

10. Further, failure to recognize Mr. Scott's court order would be denying an enforceable decree handed down by a court in this very venue.

11. Finally, Petitioner/Movant claims Mr. Scott's Iowa birth certificate, which shows him as male, should be dismissed as being irrelevant. However, Petitioner has presented no legal document from Iowa's Bureau of Health Statistics or any other government entity that would even call Mr. Scott's birth certificate into question. Petitioner has cited only responses Mr. Scott

made in a request for admissions, throughout which Mr. Scott correctly maintains he possesses an original birth certificate from the state of Iowa listing his name as James Allan Scott and his sex as male. The court must accept the legitimacy of Mr. Scott's birth certificate as issued by the State of Iowa.

12. Petitioner can show no evidence or proof countering the legitimacy of Mr. Scott's certified Iowa birth certificate. In the absence of that evidence, Petitioner/Movant has fallen far short of her burden for summary judgment based on this alone.

K. EQUAL PROTECTION AND THE FUNDAMENTAL RIGHT TO MARRY

1. Sex reassignment surgery is irreversible. After undergoing this type of surgery, a transsexual will appear completely as their harmonized gender. If a court were to rule that a post-operative transsexual, who was born with male genitals but who now has all the physical characteristics of a woman, cannot marry a man because it would constitute a same-sex marriage, that might assume the court is saying this transsexual woman can only marry another woman. Not only would this be anathema to the desires of any heterosexual (transsexual) woman, but would also effectively allow an exception to the ban on same-sex marriages, which clearly violates public policy in Texas.

2. If that were the extent of the dilemma, the question then would become whether courts should approve what the community would view as a heterosexual marriage between a post-operative transsexual woman and a genetic man, or endorse what would appear to the world to be a same-sex marriage between that same transsexual woman and another woman. Indeed, sexual orientation (attraction to another) is quite distinct from gender identity, and that transsexual woman would be physically and behaviorally indistinguishable in every way from a biological woman. Thus, under the Petitioner's theory, if that transsexual with a woman's body and mind wants to marry someone, the state is forcing her to marry and have sex with someone else with a woman's body and mind. The state of Texas effectively would be imposing what both women, and all of society, would view as a same-sex marriage.

3. However, that is not the full extent of the dilemma. As established above, a transsexual woman would not be able to establish a legitimate marriage with a genetic man because the state would maintain the power to step in, post facto, and declare that marriage void. At the same time, a transsexual woman – who now has undergone irreversible surgery, and whose state-

issued and federally issued identity documents all show her to be female – cannot marry a genetic female, because she, too, would possess only identity documents showing her to be female. The state of Texas bans same-sex marriages. A county clerk, upon seeing "female" on the identity documents of both parties who are requesting a marriage license, would be bound by Texas law to deny the license.

4. Because the marriage between a transsexual woman and genetic man (or the reverse) would be held void from the beginning, and because that same transsexual woman would lawfully be denied a marriage license with a genetic woman (or the reverse), the state of Texas would be denying all transsexuals the right to marry anyone. The same would hold true for intersexed individuals and those with genetic anomalies, as discussed supra.

5. It is well established that there is a fundamental right to marriage under the Equal Protection Clause of the 14th Amendment to the U.S. Constitution, a right articulated in the landmark *Loving v. Virginia* case. *Loving v. Virginia*, 388 U.S. 1 (1967). *See also Turner v. Safley*, 482 U.S. 78 (1987); *Zablocki v. Wisconsin*, 434 U.S. 374 (1978). Thus, the policy under Texas law as put forth by *Littleton*, and as supported by the Petitioner in the current case, is contrary to the Equal Protection clause of the U.S. Constitution. Thus, the Littleton decision supports a policy that is patently unconstitutional.

L. EQUITABLE ESTOPPEL

1. Ms. Robertson was well aware of Mr. Scott's transsexual status long before the two became husband and wife and remained in a 12-year long marriage. Exhibit K. Thus, the petitioner entered the marriage with full knowledge and support of the spouse's transsexual identity. Further, Mr. Scott's transition was complete prior to the marriage. Exhibits F, G, and H. The Petitioner willingly married Mr. Scott. Exhibit K. She has held Mr. Scott out as her husband, they purchased a home as husband and wife, and for their entire married life, the couple has filed their federal tax returns as "Married, Filing Jointly." Exhibits L, M and N.

2. Mr. Scott has lived as a spouse to the petitioner, contributing to the marriage and to the marital estate, investing fully in the marital relationship under the correct belief they had a marriage. The petitioner now is attempting to sever the marriage, not through a divorce action, but by claiming a marriage never existed by asking the court now to declare the marriage void.

3. The distinction in results between the two actions – divorce versus nullification – largely comes down to one consideration only, which is financial. The petitioner is asking this court to set aside the community property laws governing the marital estate and deny the respondent a just and right division, thus enabling the petitioner to avoid the legal obligation to divide the community property and assets that rightfully belong equally to both parties. Further, were the situation reversed – meaning, if Mr. Scott were the breadwinner and held the couple's assets in his name, and the Petitioner were disabled with no means of supporting herself – it is inconceivable that the Petitioner would claim the marriage was void rather than file a divorce action.

4. To rule in the petitioner's favor would result in the unjust enrichment of the petitioner at the expense of the respondent. Equity demands otherwise. The legal grounds and the facts of this case all urge and support the finding of a legitimate marriage between these two parties. However, even if the court were to hold that this voidance claim could proceed, justice requires the petitioner be estopped from making the claim before this court. To find otherwise would put countless others at risk, those who will have spent many years investing in a marriage only to find the legitimacy of their marriages challenged and nullified by those seeking financial gain in a divorce or estate/probate action.

M. PRESUMPTION OF VALIDITY REMAINS INTACT

1. Ms. Robertson can present no argument sufficient to overcome the state's policy that a marriage should be presumed valid. She asks this court to consider this marriage to be a same-sex marriage, but this argument clearly against the legislative intent in their 2009 amendment of 2.005. *See* Tex. Fam. Code. § 2.005(b)(8). At the very least, the lack of any cognizable test for determining the sex of a post-op transsexual for purposes of marriage would present a fact question sufficient to preclude a finding of summary judgment in favor of Petitioner.

N. REBUTTAL OF ARGUMENTS FROM PETITIONER'S MOTION FOR SUMMARY JUDGMENT

1. To support her argument in Petitioner's Brief Supporting Motion for Summary Judgment, Petitioner cites two cases from Texas. One is *Littleton v. Prange*, 9 S.W.3d 223, discussed in detail supra. Petitioner also refers to *Mireles v. Jack.* We believe Petitioner is referring to *Mireles v. Mireles*, WL 884815, S.W.3d (Tex.App.—Houston [1st] 2009). While the

facts in *Mireles* are somewhat similar to those in the present case, there is a significant distinction between the two: this appeal was not based on the merits or facts of the case. The question of whether the marriage was void as a matter of law was never at issue. *See id.* The court did not declare the marriage void – the parties themselves stipulated to that for reasons wholly unrelated to the issues at hand. *Id.* at 2. Indeed, in contrast to Petitioner's position that *Mireles* dealt with a substantive question over the right to marriage, in reality the *Mireles* decision was limited to addressing a purely procedural issue. The issue dealt with the differences between a bill of review and a collateral attack on a previous judgment, which has no bearing on the present case. This is an appeal based procedurally on declaring the judgment void. Perhaps Petitioner confuses the concept of "declaring a judgment void" with the concept of "a judgment that declares a marriage void."

2. Be that as it may, Petitioner's argument is that, because the appellate court affirmed the appellee's attack of initial trial court ruling on procedural grounds, this somehow gives credence to the trial court's ruling on legal grounds. This is a logical falsehood. This appellate case is good law only for determining that, despite naming the motion a "bill of review," it can be determined a collateral attack, and thus the trial court was able to overturn the initial ruling. This case has nothing to do with determining the gender of an individual.

3. As further authority, Petitioner cites *Corbett v. Corbett,* 2 W.L.R., 1306 (P.D.A.1970), 2 All E.R. 33, 1970 WL 29661 an English case nullifying the marriage between a post-operative transsexual and a member of the royal family. However, *Corbett* has been overruled by operation of law. Seven years ago, Parliament passed the Gender Recognition Act of 2004, which states that, where a full gender recognition certificate is issued to a person, the person's gender becomes, for all purposes, the acquired gender.

4. Petitioner cites *Anonymous v. Anonymous*, 325 N.Y.S.2d 499 (1971), as support. The facts of *Anonymous* are clearly distinguishable from the instant case in that the bride failed to inform the groom that she was transsexual before they wed, they never lived together before or after the marriage, and they never had sexual contact. 325 N.Y.S.2d at 500. The marriage was annulled based on what could be considered fraudulent concealment of the bride's transsexual status. In the present case, Ms. Robertson knew of Mr. Scott's transsexual status and supported his transition and surgery prior to their marriage. Further, they lived and slept together for 12 years, and held themselves out to the world as husband and wife.

5. Furthermore, *Anonymous* has now been overturned by operation of law. On July 24, 2011, New York's Marriage Equality Act took effect, making New York the sixth and largest state to legalize same-sex marriage. 2011 N.Y. Laws A8354-2011. Although the present case is not about same-sex marriage, its legalization in New York renders moot the entire question of whether a transsexual is his or her designated gender for the purpose of marriage. In other words, it matters not whether the state views a transsexual man as allowed to marry a woman. In New York, a person of any sex can marry a person of any sex, nullifying the basis of the *Anonymous* court's holding.

6. One of the Ohio cases Petitioner cites in support, *In re Ladrach*, 513 N.E.2d 828 (Ohio Probate Ct. 1987), is distinguishable from the instant case in that *Ladrach* deals with an inability to obtain a marriage license. Mr. Scott and the Petitioner lawfully obtained a marriage license, the couple has been married for 12 years, and Texas maintains a strong presumption of validity of a marriage. Further, the court stated it was for the legislature to decide whether a transsexual woman would be permitted to marry a man. Without any statutory guidance, the court ruled against the validity of the marriage.

7. A number of other cases that held a marriage to be void if between a transsexual man and a woman, or vice-versa, also claimed a lack of statutory guidance and maintained it was up to the legislature to speak to the issue. See, e.g., *Kantaras v. Kantaras*, 884 So.2d 155 (Fla.App. 2004); *In re Marriage License for Nash*, 2003 WL 23097095 (Ohio App. 2003); *In re Estate of Gardiner*, 42 P.3d 120 (Kan. 2002).

8. The Petitioner cites only one of a number of cases upholding the right of a transsexual to marry, and she misrepresents the holding itself. In *M.T v. J.T.*, 355 A.2d 204 (N.J.Super.A.D. 1976), the court declared a marriage a man and a transsexual woman to be valid. Significantly, the court necessarily implied the ruling would hold for any transsexual, stating, "In so ruling, we do no more than give legal effect to a fait accompli, based upon medical judgment and action which are irreversible. Such recognition will promote the individual's quest for inner peace and personal happiness, while in no way disserving any societal interest, principle of public order or precept of morality." 355 A.2d at 211.

9. The Petitioner correctly quotes the court as saying, "we are impelled to the conclusion that, for marital purposes, if the anatomical or genital features of a genuine transsexual are made to conform to the person's gender, psyche or psychological sex, then identity by sex must be

governed by the congruence of these standards." 355 A.2d at 209. However, the Petitioner then incorrectly claims the court's statement applies only to a transsexual woman who has undergone sex reconstructive surgery to remove the penis and construct a vagina and breasts. The Petitioner concludes that, because Mr. Scott was born with a vagina and had his breasts removed, the decision does not apply to him.

10. First, the court made clear that it was stating universal principles based on this case, which happened to involve a transsexual woman. Second, for the court to hold that a transsexual woman could marry a man, but that a transsexual man could not marry a woman, would constitute an endorsement by the court of sex discrimination. Finally, the Petitioner asserts that, because Mr. Scott began life with the genitals that a transsexual woman gains through surgery, he fails to qualify. Given that it would be impossible for Mr. Scott to surgically remove a penis he never had, and further would defeat the very "congruence" that would govern his "identity of sex," the assertion is both irrelevant and illogical.

11. The Petitioner failed to cite a number of other cases that fully uphold a transsexual's right to marry. An New Zealand case, discussed in *Littleton*, which finds it discussed in 7 Otago L. Rev. 556 (1989-1992), upholds the right of a transsexual to marry a person whose sex is opposite of the transsexual's adopted gender. Quoting from the decision, "The question would then become whether courts should approve seemingly heterosexual marriages between a post-operative transsexual female and a genetic male, rather than an apparent same-sex marriage between a post-operative transsexual female and a genetic female." *Littleton* at 229.

12. *In re Dickenson*, 1978 WL 891 (Pa.Com.Pl. 1978), allows not only for sex change of transsexual, but explicitly states that the post-op male-to-female is to be legally recognized as a female. The court states that there is no "gainful purpose in denying...an individual from assuming legally the sex he or she has already acquired surgically and to a medical certainty." *In re Dickerson*, 1978 WL 891, 2 (Penn. 1978).

13. Glenn v. Brumby, 724 F.Supp.2d 1284 (N.D. Ga. 2010), determined there was sufficient evidence that statements of World Professional Association for Transgender Health (WPATH) were accepted in medical community, and thus those statements were admissible for summary judgment purposes.

14. In a Maryland case, *In re Heilig*, 816 A.2d 68 (Md. 2003), the court remanded after holding that lower court erred "in broadly concluding, apparently as a matter of law, that gender was not subject to modification or adjustment." 816 A.2d at 71.

15. *Morin v. Morin*, 2007 WL 5313306 (Vt.) was a divorce case in which one party was transgendered. The court discusses it only in the context of distributing marital assets, and posing the question of whether the other party was aware of the transsexual nature of the other. The opinion implies that one party being transsexual does not preclude finding of divorce.

16. In the conclusion to her brief, Petitioner asserts that "every state that has been asked to determine the sex of a transsexual for the purposes of marriage, except one, has answered that it [sic] sex is determined at birth." See Petitioner's Motion for Summary Judgment, § 7.B. At best, this statement can be characterized as inaccurate. Within the cases cited in this section alone, states that have not reached this answer include Maryland, Vermont, Georgia, New Jersey and Pennsylvania, and New York has thrown out its previous answer through operation of law, bringing the total to six. The full slate of states, cited by the Petitioner/Movant herself, with court opinions deciding a person's sex is "determined at birth" – specifically by a cursory examination of the apparent genitals of the infant – total three: Florida, Kansas and Ohio. It is clear the trend of the nation is moving away from the position taken by the Petitioner in the present case.

17. The Petitioner makes a number of other unfounded assumptions and misstatements of fact. Under the section marked "Arguments and Authorities," Petitioner mischaracterizes the legal issue as whether there can be a valid marriage between a woman and a person "born as a woman who wants to be a man" (emphasis added). See Petitioner's Motion, §5.iii. This is not an issue of a woman wanting to be a man. This involves a person who has the full psychological sense of a man's identity, but whose body has female-appearing genitals.

18. Petitioner insists that two appellate court decisions in Texas support her position. This is patently untrue. See Petitioner's Motion for Summary Judgment, § 7.B. There is only *Littleton*, which holds no mandatory authority in Dallas County.

19. Petitioner insists that "both parties admit and acknowledge being born female." See Petitioner's Motion for Summary Judgment, § 7.A. Again, this statement is patently untrue. Mr. Scott acknowledges being born with female genitals, which is not the same thing.

20. Among other glaring errors, Petitioner claims that the Texas Supreme Court "appears to agree with the San Antonio Court of Appeals." See Petitioner's Motion for Summary Judgment, § 7.B. Perhaps Petitioner confuses the notation "petition denied" with the notation "petition refused." See Respondent's discussion supra, this brief.

O. THE TEXAS LEGISLATURE HAS SPOKEN – LITTLETON OVERTURNED BY OPERATION OF LAW

1. Given that there is no legal definition of male or female, nor a statutory test of what defines a man or a woman for the purpose of marriage (or any other purpose), those cases opposing a transsexual man marrying a woman (or vice-versa) have consistently called on the respective legislatures to speak to the issue. This holds for cases both within Texas and outside her borders. (Emphasis added.)

2. The Texas case most cited is *Littleton v. Prange*, 9 S.W.3d 223 (Tex.App.—San Antonio 1999). In it, the court states that, "it is for the legislature…to determine what guidelines should govern the recognition of marriage." *Id.* at 230. The court goes further to state "our responsibility in this case is to determine, in the absence of legislatively-established guidelines, [whether] a jury can be called upon to decide the legality of such matters." *Id.*

3. Examples from outside of Texas include *Kantaras v. Kantaras*, 884 So.2d 155, 161 (Fla.App.2 Dist. 2004) ("the question of whether a postoperative transsexual is authorized to marry a member of their birth sex is a matter for the Florida legislature and not the Florida courts to decide."), *In re Estate of Gardiner*, 42 P.3d 120, 137 (Kan. 2002) ("the validity of [the] marriage…is a question of public policy to be addressed by the legislature and not by this court."), and *In re Ladrach*, 513 N.E.2d 828, 832 (Ohio. Prob. 1987) ("it is the court's opinion that the legislature should change the statutes, if it is to be the public policy…to issue marriage licenses to post-operative transsexuals.").

4. Littleton v. Prange, 9 S.W.3d 223 (Tex. App. 1999) and numerous other court decisions have held that the sex status of transsexuals should be left to the legislature. The Texas Legislature has now spoken on the issue of transsexual marriage.

5. On September 1, 2009, the Texas legislature enacted an amendment to the Texas Family Code that clearly recognizes a transsexual's right to marry. To obtain a marriage certificate, proof of age and identity of each applicant must be provided to the county clerk. Tex.

Fam. Code § 2.005(a) (Vernon's 2009). In 2009, the legislature amended section 2.005 of the Family Code to provide a long list of specific documents one could show a clerk as proof. The statute reads, in pertinent part:

> **§ 2.005. Proof of Identity and Age**
>
> (a) The county clerk shall require proof of the identity and age of each applicant.
>
> (b) The proof must be established by:
>
> .....
>
> (8) an original or certified copy of a court order relating to the applicant's name change or sex change; (emphasis added)

6. Explicit reference to this documentation establishes that there was legislative intent to recognize the elements of identity as would be stated in such a court order. Such documentation shows the sex of the individual as the sex designated following the sex change or transition, thus affirming that the state recognizes person's re-designated sex as that person's sex for the purpose of obtaining a marriage license. Texas law explicitly forbids recognition of a marriage or marital relationship between two people of the same sex, and further defines marriage as being between one man and one woman, concluding that any marriage between two people of the same sex is void. The Texas legislature would not explicitly recognize the legitimacy of a certificate for a marriage that is void under Texas law. Thus, this logically and necessarily means that the legislature recognizes the legitimacy of a marriage between a man and a transsexual woman, or between a woman and a transsexual man. There can be no other conclusion.

7. In the present case, Mr. Scott obtained a birth certificate issued by the state of Iowa that shows his name as James Allan Scott and his gender as male. He obtained other documents, such as a driver's license and a passport, showing the same name and gender. All of this followed his petitioning for and obtaining a decree granting a name and gender change for Mr. Scott, ordered by the 134th Judicial District in Dallas County, Texas.

The Texas Legislature has deemed all of these documents, with emphasis here on a court order showing change of sex, to be sufficient proof of identity for purposes of marriage. The addition of the term "sex change" to the statute in 2009 clearly shows that the Texas Legislature intended to allow transsexual individuals to marry a person opposite their harmonized gender.

The law of the state of Texas recognizes Mr. Scott as a man, and thus recognizes the marriage between Mr. Scott and Ms. Robertson as a valid, legitimate marriage.

P. CONCLUSION

1. No mandatory authority exists in this venue to support Petitioner's claim. No legal test or controlling authority exists to guide a court in how to determine who is a man or who is a woman for the purpose of marriage. With a strong presumption that a marriage is valid, and without a test to clearly show a marriage is not, a court cannot justify acting against the state's public policy by dissolving a marriage.

2. The one case of persuasive authority on which Petitioner relies so heavily, *Littleton v. Prange*, has been overturned by operation of law, has never had precedential weight in this venue, is distinguishable from the present case, was significantly flawed when it was decided, and has become more so over time as more is learned about the nature and science of gender identity disorder. The opinion by the honorable justice appeared to be based, not on law or equity or supportable statutory construction, but on a personal opinion based on a lack of knowledge or understanding of the science, psychology and nature of gender identity. The holding nullified what had been a legitimate marriage, and put countless others at risk. Especially ironic is the fact that, in his decision, Justice Hardberger stated that the court should not be making law in the absence of legislative guidance, but then proceeded to do so.

3. The decision created an unconstitutional conundrum for every transsexual, intersexed person, or someone who may have one of a number of genetic anomalies. A transsexual man, following an irreversible transition and identified on all state documentation as male, cannot marry another man. This would violate the state's firmly established ban on same-sex marriage. However, under the policy endorsed by *Littleton v. Prange* and the Petitioner, he cannot marry a woman. To be accurate, he <u>can</u> marry her – Mr. Scott did marry Ms. Robertson with a legally obtained birth certificate and in a church ceremony – but, if the marriage is a nullity from the start, he must live in daily fear that the marriage could be declared void if it meant financial gain to a spouse, the spouse's family, or anyone else with standing to sue. Thus, a transsexual in the state of Texas cannot legitimately marry anyone, which defies the fundamental right to marry as guaranteed by the Equal Protection Clause of the 14th Amendment and articulated in *Loving*.

4. Further, the position held by *Littleton* creates a double standard regarding identity documents, whereby the state or a court may choose to accept an amended or replaced birth certificate that has corrected a mistake it finds acceptable, but reject a changed birth certificate if the correction was for reasons the court finds distasteful or confusing. Further, to extend that rejection to a birth certificate from another state, regardless of Petitioner's strained classification of a document that is merely ministerial, threatens the U.S. Constitution's Full Faith and Credit Clause.

5. In addition, equitable estoppel should prevent such a marriage from being declared void. Mr. Scott, in good faith, invested more than 12 years in his marriage to Ms. Robertson. Mr. Scott, who is disabled and deals with a host of chronic medical conditions, has been unable to work outside the home. Thus, Mr. Scott's role was that of "house husband." Ms. Robertson was the primary breadwinner throughout their marriage. This necessarily means that all of the assets the couple has accumulated over those 12 years, including investments and retirement accounts, will no longer be considered community property to be divided, but the sole and separate property of Ms. Robertson. Mr. Scott, disabled and unable to work, would be left with nothing.

6. The key issue has revolved around whether Mr. Scott, a transsexual man, should be considered a man. Overwhelming scientific and behavioral research shows that Mr. Scott and all other transsexual men, are men between the ears, have the physical appearance of a man, and can enjoy a satisfying sexual life with a partner. Any transsexual woman should be considered a woman, because their brains are female brains and their bodies are female bodies. The only distinction, other than potential chromosome patterns, is that a transsexual is infertile. But so are many genetic men and women who do not have gender identity disorder. And it is important to note that it serves no compelling state interest to hold that a transsexual man cannot marry a woman, or vice-versa, which strikes another constitutional issue involving a liberty interest under Equal Protection.

7. But the overwhelming authority that controls in this decision is the state legislature. Littleton made it clear that the legislature needed to speak to the issue, and on September 1, 2009, it did. The state passed an amendment to the Family Code that, in the plain language of the statute, says that a transsexual has the right to request a marriage certificate with her change of sex documentation. The only legal and logical interpretation to section 2.005(b)(8) is that, in

the state of Texas, the legislature has affirmed that a transsexual has the right to marry as his or her adopted gender.

8. *Littleton*, a single decision that was never mandatory authority anywhere outside the Court of Appeals' 4th District, has been overturned by operation of law, thus eviscerating the only legal authority the Petitioner has and could rely on. Petitioner cannot show that summary judgment must be granted as a matter of law because there exists no law upon which to grant judgment. This court should deny Petitioner's motion and allow this case to proceed as a divorce action.

Q. PRAYER

1. Respondent and Non-Movant James Allan Scott prays that, upon hearing this matter, the Court finds the Petitioner has failed to meet her burden and denies Petitioner's Motion for Summary Judgment.

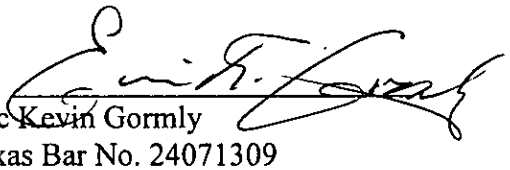
2. Respondent prays the Court will hear his Motion to Dismiss Ms. Robertson's Second Amended Petition to Declare the Marriage Void, and dismiss Petitioner's claim.

3. Respondent prays the Court will allow Respondent's action for divorce to proceed as the only live pleading in this matter.

4. Respondent prays for any other relief to which Respondent justly may be entitled.

Respectfully submitted,

The Gormly Law Firm, PLLC

By: 

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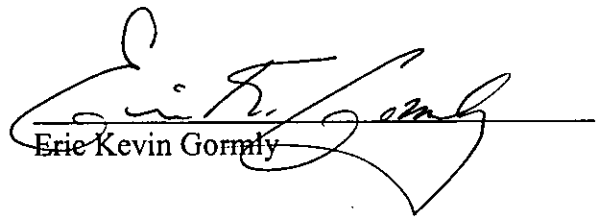
CERTIFICATE OF SERVICE

I certify that a copy of Respondent's Reply to Petitioner's Brief in Support of Motion for Summary Judgment was served on Petitioner Rebecca Louise Robertson, through counsel of record, Thomas Nicol, whose address is 901 Main Street, Suite 6300, Dallas, Texas, 75202, by hand delivery, on October 5, 2011.



Erie Kevin Gormly

EXHIBIT A

Policy bulletin found at

http://www.aetna.com/cpb/medical/data/600_699/0615.html

on October 3, 2011.

Aetna

Clinical Policy Bulletin: Gender Reassignment Surgery

Number: 0615

Policy

Note: Most Aetna plans exclude coverage of sex change surgery (gender reassignment surgery, transgender surgery) or any treatment of gender identity disorders. Please check benefit plan descriptions.

Aetna considers sex reassignment surgery medically necessary when all of the following criteria are met:

I. Member is at least 18 years old; *and*

II. Member has met criteria for the diagnosis of "true" transsexualism, including:

- A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; *and*
- A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; *and*
- Absence of physical inter-sex of genetic abnormality; *and*
- Does not gain sexual arousal from cross-dressing; *and*
- Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; *and*
- Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; *and*
- Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

III. Member has completed a recognized program of transgender identity treatment as evidenced by all of the following:

- A qualified mental health professional* who has been acquainted with the member for at least 18 months recommends sex reassignment surgery documented in the form of a written comprehensive evaluation; *and*

- For genital surgical sex reassignment, a second concurring recommendation by another qualified mental health professional * must be documented in the form of a written expert opinion**; *and*
- For genital surgical sex reassignment, member has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteraton of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment); *and*
- Member has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and post surgical rehabilitation requirements of the planned surgery; *and*
- Psychotherapy is not an absolute requirement for surgery unless the mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); *and*
- The member has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; *and*
- Unless medically contraindicated, member has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a mental health professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience).

* At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.). Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit. Please check benefit plan descriptions.

** Either two separate letters or one letter with two signatures is acceptable.

Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.

Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip

reduction, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for transgender persons:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
2. Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Background

Transsexualism is "a gender identity disorder in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time." People who wish to change their sex may be referred to as "Transsexuals" or as people suffering from "Gender Dysphoria" (meaning unhappiness with one's gender).

Transsexuals usually present to the medical profession with a diagnosis of transsexualism, a sophisticated understanding of their condition, and a desired course of treatment, that is, hormone therapy and sex-reassignment surgery. The therapeutic approach to gender identity disorder consists of three parts: a real life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics (Day, 2002). The most typical order, if all three elements are undertaken, is hormones followed by real life experience and, finally, surgery.

For male to female transsexuals selected for surgery, procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty), breast augmentation and cosmetic surgery (facial reshaping, rhinoplasty, abdominoplasty, laryngeal shaving, vocal cord shortening, hair transplants) (Day, 2002). For female to male transsexuals, surgical procedures may include genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), mastectomy, chest wall contouring and cosmetic surgery (Day, 1992).

Due to the far-reaching and irreversible results of hormonal and/or surgical transformational measures, a careful diagnosis and differential diagnosis is absolutely vital to the patient's best interest. In and of themselves, a patient's self-diagnosis and the intensity of his desire for sex reassignment cannot be viewed as reliable indicators of transsexuality. A vital part of the long-term diagnostic therapy is the so-called real-life experience, in which the patient lives as a member of the desired sex continually and in all social spheres in order to accumulate necessary experience. Experience in specialist Gender Identity Units has shown that only about 15% of male transsexuals and 90% of female transsexuals are considered suitable for surgery or still desire it after specialist psychiatric care and a prolonged period of observation used to identify the relatively rare "true" transsexual from the more common "secondary" transsexual.

Hormone therapy and sex-reassignment surgery are superficial changes in comparison to the major psychological adjustments necessary in changing sex.

Treatment should concentrate on the psychological adjustment, with hormone therapy and sex-reassignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Psychiatric care may need to be continued for many years after sex-reassignment surgery. The technical success of sex-reassignment surgery is greater for male-to-female transsexuals than female-to-male transsexuals, and continues to improve as new techniques are developed. The overall success of treatment depends partly on the technical success of the surgery, but more crucially on the psychological adjustment of the transsexual, and the support from family, friends, employers and the medical profession.

CPT Codes / HCPCS Codes / ICD-9 Codes

CPT codes covered if selection criteria are met:

19301, 19303 -
19304

53430

54125

54400 - 54417

54520

54660

54690

55175

55180

55970

55980

56625

56800

56805

56810

57106 - 57107,
57110 - 57111

57291 - 57292

57335

58150, 58180,
58260 - 58262,

58275 - 58291,
58541 - 58544,
58550 - 58554

58570 - 58573

58661

58720

CPT codes not covered for indications listed in the CPB [considered cosmetic]:

11950 - 11954

15780 - 15787

15788 - 15793

15820 - 15823

15824 - 15828

15830 - 15839

15876 - 15879

17380

19316

19318

19324 - 19325

19340

19342

19350

21120 - 21123

21125 - 21127

30400 - 30420

30430 - 30450

Other CPT codes related to the CPB:

90804 - 90857

ICD-9 codes covered if selection criteria are met:

302.50 - 302.53 Trans-sexualism

302.85	Gender identity disorder in adolescents or adults

ICD-9 codes not covered for indications listed in the CPB:

293.0 - 302.4, 302.6 - 302.84, 302.89 - 319	Mental disorders [other than transexualism and gender identity disorder]
752.7	Indeterminate sex and pseudohermaphroditism
758.0 - 758.9	Chromosomal anomalies

The above policy is based on the following references:

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EXHIBIT B

The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Version

February, 2001

Committee Members: Walter Meyer III M.D. (Chairperson), Walter O. Bockting Ph.D., Peggy Cohen-Kettenis Ph.D., Eli Coleman Ph.D., Domenico DiCeglie M.D., Holly Devor Ph.D., Louis Gooren M.D., Ph.D., J. Joris Hage M.D., Sheila Kirk M.D., Bram Kuiper Ph.D., Donald Laub M.D., Anne Lawrence M.D., Yvon Menard M.D., Stan Monstrey M.D., Jude Patton PA-C, Leah Schaefer Ed.D., Alice Webb D.H.S., Connie Christine Wheeler Ph.D.

This is the sixth version of the Standards of Care since the original 1979 document.
Previous revisions were in 1980, 1981, 1990, and 1998.

Table of Contents:

I. Introductory Concepts

The Purpose of the Standards of Care. The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation.

The Overarching Treatment Goal. The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

The Standards of Care Are Clinical Guidelines. The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders. When eligibility

requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may modify them. Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol. These departures should be recognized as such, explained to the patient, and documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve.

The Clinical Threshold. A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person's development, become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity. The person's struggles are then variously informally referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, gender conflict, or transsexualism. Such struggles are known to occur from the preschool years to old age and have many alternate forms. These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity, and the perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures--the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders--Fourth Edition (DSM-IV)--they are formally designated as suffering from a gender identity disorder (GID). Some persons with GID exceed another threshold--they persistently possess a wish for surgical transformation of their bodies.

Two Primary Populations with GID Exist -- Biological Males and Biological Females. The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biologic, social, psychological, and economic dilemmas of each sex. All patients, however, should follow the SOC.

II. Epidemiological Considerations

Prevalence. When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bona fide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates of prevalence for transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people, and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons' gender identity disorders fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

Natural History of Gender Identity Disorders. Ideally, prospective data about the natural history of gender identity struggles would inform all treatment decisions. These are lacking, except for the demonstration that, without therapy, most boys and girls with gender identity disorders outgrow their wish to change sex and gender. After the diagnosis of GID is made the therapeutic approach usually includes three elements or phases (sometimes labeled triadic therapy): a real-life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics. Five less firmly scientifically established observations prevent clinicians from prescribing the triadic therapy based on diagnosis alone: 1) some carefully diagnosed persons spontaneously change their aspirations; 2) others make more comfortable accommodations to their gender identities without medical interventions; 3) others give up their wish to follow the triadic sequence during psychotherapy; 4) some gender identity clinics have an unexplained high drop out rate; and 5) the percentage of persons who are not benefited from the triadic therapy varies significantly from study to study. Many persons with GID will desire all three elements of triadic therapy. Typically, triadic therapy takes place in the order of hormones = = > real-life experience = = > surgery, or sometimes: real-life experience = = > hormones = = > surgery. For some biologic females, the preferred sequence may be hormones = = > breast surgery = = > real-life experience. However, the diagnosis of GID invites the consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy.

Cultural Differences in Gender Identity Variance throughout the World. Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.

III. Diagnostic Nomenclature

The Five Elements of Clinical Work. Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

The Development of a Nomenclature. The term *transexxual* emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term *true transsexual.* The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and

adulthood; 2) minimal or no sexual arousal to cross-dressing; and 3) no heterosexual interest, relative to their anatomic sex. True transsexuals could be of either sex. True transsexual males were distinguished from males who arrived at the desire to change sex and gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and thatsome of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of true transsexual females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender variant behaviors such as female cross-dressing remained unseen by clinicians. The term "gender dysphoria syndrome" was later adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature.

The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

The DSM-IV. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to females; attracted to both; or attracted to neither. This subclassification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was **not** intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner -- that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

The ICD-10. The ICD-10 now provides five diagnoses for the gender identity disorders (F64):

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Dual-role Transvestism (F64.1) has three criteria:
1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
2. There is no sexual motivation for the cross-dressing;
3. The individual has no desire for a permanent change to the opposite sex.

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys.
For girls:

1. The individual shows persistent and intense distress about being a girl, and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages to being a boy) or insists that she is a boy;
2. Either of the following must be present:
    a. Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing;
    b. Persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
        1. An assertion that she has, or will grow, a penis;
        2. Rejection of urination in a sitting position;
        3. Assertion that she does not want to grow breasts or menstruate.
3. The girl has not yet reached puberty;
4. The disorder must have been present for at least 6 months.

For boys:

1. The individual shows persistent and intense distress about being a boy, and has a desire to be a girl, or, more rarely, insists that he is a girl.
2. Either of the following must be present:
    a. Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games, and activities;
    b. Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
        1. That he will grow up to become a woman (not merely in the role);
        2. That his penis or testes are disgusting or will disappear;
        3. That it would be better not to have a penis or testes.
3. The boy has not yet reached puberty;
4. The disorder must have been present for at least 6 months.

Other Gender Identity Disorders (F64.8) has no specific criteria.

Gender Identity Disorder, Unspecified has no specific criteria.

Either of the previous two diagnoses could be used for those with an intersexed condition.

The purpose of the DSM-IV and ICD-10 is to guide treatment and research. Different professional groups created these nomenclatures through consensus processes at different times. There is an expectation that the differences between the systems will be eliminated in the future. At this point, the specific diagnoses are based more on clinical reasoning than on scientific investigation.

Are Gender Identity Disorders Mental Disorders? To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person or cause personal mental suffering. The DSM-IV and ICD-10 have defined hundreds of mental disorders which vary in onset, duration, pathogenesis, functional disability, and treatability. The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments.

IV. The Mental Health Professional

The Ten Tasks of the Mental Health Professional. Mental health professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

1. To accurately diagnose the individual's gender disorder;
2. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
3. To counsel the individual about the range of treatment options and their implications;
4. To engage in psychotherapy;
5. To ascertain eligibility and readiness for hormone and surgical therapy;
6. To make formal recommendations to medical and surgical colleagues;
7. To document their patient's relevant history in a letter of recommendation;
8. To be a colleague on a team of professionals with an interest in the gender identity disorders;
9. To educate family members, employers, and institutions about gender identity disorders;
10. To be available for follow-up of previously seen gender patients.

The Adult-Specialist. The education of the mental health professional who specializes in adult gender identity disorders rests upon basic general clinical competence in diagnosis and treatment of mental or emotional disorders. Clinical training may occur within any formally credentialing discipline -- for example, psychology, psychiatry, social work, counseling, or nursing. The following are the recommended minimal credentials for special competence with the gender identity disorders:

1. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national

or regional accrediting board. The mental health professional should have documented credentials from a proper training facility and a licensing board.
2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
3. Documented supervised training and competence in psychotherapy.
4. Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.

The Child-Specialist. The professional who evaluates and offers therapy for a child or early adolescent with GID should have been trained in childhood and adolescent developmental psychopathology. The professional should be competent in diagnosing and treating the ordinary problems of children and adolescents. These requirements are in addition to the adult-specialist requirement.

The Differences between Eligibility and Readiness. The SOC provide recommendations for eligibility requirements for hormones and surgery. Without first meeting these recommended eligibility requirements, the patient and the therapist should not request hormones or surgery. An example of an eligibility requirement is: a person must live full time in the preferred gender for twelve months prior to genital surgery. To meet this criterion, the professional needs to document that the real-life experience has occurred for this duration. Meeting readiness criteria -- further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role -- is more complicated, because it rests upon the clinician's and the patient's judgment.

The Mental Health Professional's Relationship to the Prescribing Physician and Surgeon. Mental health professionals who recommend hormonal and surgical therapy share the legal and ethical responsibility for that decision with the physician who undertakes the treatment. Hormonal treatment can often alleviate anxiety and depression in people without the use of additional psychotropic medications. Some individuals, however, need psychotropic medication prior to, or concurrent with, taking hormones or having surgery. The mental health professional is expected to make this assessment, and see that the appropriate psychotropic medications are offered to the patient. The presence of psychiatric co-morbidities does not necessarily preclude hormonal or surgical treatment, but some diagnoses pose difficult treatment dilemmas and may delay or preclude the use of either treatment.

The Mental Health Professional's Documentation Letter for Hormone Therapy or Surgery Should Succinctly Specify:

1. The patient's general identifying characteristics;
2. The initial and evolving gender, sexual, and other psychiatric diagnoses;
3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
4. The eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery;
5. The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;
6. Whether the author of the report is part of a gender team;

7. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document.

The organization and completeness of these letters provide the hormone-prescribing physician and the surgeon an important degree of assurance that mental health professional is knowledgeable and competent concerning gender identity disorders.

One Letter is Required for Instituting Hormone Therapy, or for Breast Surgery. One letter from a mental health professional, including the above seven points, written to the physician who will be responsible for the patient's medical treatment, is sufficient for instituting hormone therapy or for a referral for breast surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

Two Letters are Generally Required for Genital Surgery. Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus.

It is ideal if mental health professionals conduct their tasks and periodically report on these processes as part of a team of other mental health professionals and nonpsychiatric physicians. One letter to the physician performing genital surgery will generally suffice as long as two mental health professionals sign it.

More commonly, however, letters of recommendation are from mental health professionals who work alone without colleagues experienced with gender identity disorders. Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are required prior to initiating genital surgery. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient. Each letter, however, is expected to cover the same topics. At least one of the letters should be an extensive report. The second letter writer, having read the first letter, may choose to offer a briefer summary and an agreement with the recommendation.

V. Assessment and Treatment of Children and Adolescents

Phenomenology. Gender identity disorders in children and adolescents are different from those seen in adults, in that a rapid and dramatic developmental process (physical, psychological and sexual) is involved. Gender identity disorders in children and adolescents are complex conditions. The young person may experience his or her phenotype sex as inconsistent with his or her own sense of gender identity. Intense distress is often experienced, particularly in adolescence, and there are frequently associated emotional and behavioral difficulties. There is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few

gender variant youths become transsexual, although many eventually develop a homosexual orientation.

Commonly seen features of gender identity conflicts in children and adolescents include a stated desire to be the other sex; cross dressing; play with games and toys usually associated with the gender with which the child identifies; avoidance of the clothing, demeanor and play normally associated with the child's sex and gender of assignment; preference for playmates or friends of the sex and gender with which the child identifies; and dislike of bodily sex characteristics and functions. Gender identity disorders are more often diagnosed in boys.

Phenomenologically, there is a qualitative difference between the way children and adolescents present their sex and gender predicaments, and the presentation of delusions or other psychotic symptoms. Delusional beliefs about their body or gender can occur in psychotic conditions but they can be distinguished from the phenomenon of a gender identity disorder. Gender identity disorders in childhood are not equivalent to those in adulthood and the former do not inevitably lead to the latter. The younger the child the less certain and perhaps more malleable the outcome.

Psychological and Social Interventions. The task of the child-specialist mental health professional is to provide assessment and treatment that broadly conforms to the following guidelines:

1. The professional should recognize and accept the gender identity problem. Acceptance and removal of secrecy can bring considerable relief.
2. The assessment should explore the nature and characteristics of the child's or adolescent's gender identity. A complete psychodiagnostic and psychiatric assessment should be performed. A complete assessment should include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child's environment are often present.
3. Therapy should focus on ameliorating any comorbid problems in the child's life, and on reducing distress the child experiences from his or her gender identity problem and other difficulties. The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with his or her gender identity. This includes issues of whether to inform others of the child's situation, and how others in the child's life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety in relation to the child's gender expression and how best to manage it. Professional network meetings can be very useful in finding appropriate solutions to these problems.

Physical Interventions. Before any physical intervention is considered, extensive exploration of psychological, family and social issues should be undertaken. Physical interventions should be addressed in the context of adolescent development. Adolescents' gender identity development can rapidly and unexpectedly evolve. An adolescent shift toward gender conformity can occur primarily to please the family, and may not persist or reflect a permanent change in gender identity. Identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility; more fluidity may return at a later stage. For these reasons, irreversible physical interventions should be delayed as long as is clinically appropriate. Pressure for physical interventions because of an adolescent's level of distress can be great and in such

circumstances a referral to a child and adolescent multi-disciplinary specialty service should be considered, in locations where these exist.

Physical interventions fall into three categories or stages:

1. Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
2. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
3. Irreversible interventions. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one state to another should not occur until there has been adequate time for the young person and his/her family to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions. Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two. If for clinical reasons it is thought to be in the patient's interest to intervene earlier, this must be managed with pediatric endocrinological advice and more than one psychiatric opinion.

Two goals justify this intervention: a) to gain time to further explore the gender identity and other developmental issues in psychotherapy; and b) to make passing easier if the adolescent continues to pursue sex and gender change. In order to provide puberty delaying hormones to an adolescent, the following criteria must be met:

1. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors;
2. sex and gender discomfort has significantly increased with the onset of puberty;
3. the family consents and participates in the therapy.

Biologic males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or antiandrogens (which block testosterone secretion or neutralize testosterone action). Biologic females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogens and progesterone) to stop menstruation.

Partially Reversible Interventions. Adolescents may be eligible to begin masculinizing or feminizing hormone therapy as early as age 16, preferably with parental consent. In many countries 16-year olds are legal adults for medical decision making, and do not require parental consent.

Mental health professional involvement is an eligibility requirement for triadic therapy during adolescence. For the implementation of the real-life experience or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months. While the number of sessions during this six-month period rests upon the clinician's judgment,

the intent is that hormones and the real-life experience be thoughtfully and recurrently considered over time. In those patients who have already begun the real-life experience prior to being seen, the professional should work closely with them and their families with the thoughtful recurrent consideration of what is happening over time.

Irreversible Interventions. Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention.

VI. Psychotherapy with Adults

A Basic Observation. Many adults with gender identity disorder find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort.

Psychotherapy is Not an Absolute Requirement for Triadic Therapy. Not every adult gender patient requires psychotherapy in order to proceed with hormone therapy, the real-life experience, hormones, or surgery. Individual programs vary to the extent that they perceive a need for psychotherapy. When the mental health professional's initial assessment leads to a recommendation for psychotherapy, the clinician should specify the goals of treatment, and estimate its frequency and duration. There is no required minimum number of psychotherapy sessions prior to hormone therapy, the real-life experience, or surgery, for three reasons: 1) patients differ widely in their abilities to attain similar goals in a specified time; 2) a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth; 3) the mental health professional can be an important support to the patient throughout all phases of gender transition. Individual programs may set eligibility criteria to some minimum number of sessions or months of psychotherapy.

The mental health professional who conducts the initial evaluation need not be the psychotherapist. If members of a gender team do not do psychotherapy, the psychotherapist should be informed that a letter describing the patient's therapy might be requested so the patient can proceed with the next phase of treatment.

Goals of Psychotherapy. Psychotherapy often provides education about a range of options not previously seriously considered by the patient. It emphasizes the need to set realistic life goals for work and relationships, and it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.

The Therapeutic Relationship. The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issues with the patient during the initial diagnostic evaluation. Other issues may be better dealt with later, after the person feels that the clinician is interested in and understands their gender identity concerns.

Ideally, the clinician's work is with the whole of the person's complexity. The goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. Even when these initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person's original sex assignment and previous gendered experience.

Processes of Psychotherapy. Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50-minutes sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity expression. Gender distress often intensifies relationship, work, and educational dilemmas.

The therapist should make clear that it is the patient's right to choose among many options. The patient can experiment over time with alternative approaches. Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness, because the therapist and patient must cooperate in defining the patient's problems, and in assessing progress in dealing with them. Collaboration can prevent a stalemate between a therapist who seems needlessly withholding of a recommendation, and a patient who seems too profoundly distrusting to freely share thoughts, feelings, events, and relationships.

Patients may benefit from psychotherapy at every stage of gender evolution. This includes the post-surgical period, when the anatomic obstacles to gender comfort have been removed, but the person may continue to feel a lack of genuine comfort and skill in living in the new gender role.

Options for Gender Adaptation. The activities and processes that are listed below have, in various combinations, helped people to find more personal comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.

Activities:

Biological Males:

1. Cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion;
2. Changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures;
3. Increasing grooming, wardrobe, and vocal expression skills.

Biological Females:

1. Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion;
2. Changing the body through breast binding, weight lifting, applying theatrical facial hair;

3. Padding underpants or wearing a penile prosthesis.

Both Genders:

1. Learning about transgender phenomena from: support groups and gender networks, communication with peers via the Internet, studying these Standards of Care, relevant lay and professional literatures about legal rights pertaining to work, relationships, and public cross-dressing;
2. Involvement in recreational activities of the desired gender;
3. Episodic cross-gender living.

Processes:

1. Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;
2. Acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression;
3. Integration of male and female gender awareness into daily living;
4. Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships.

VII. Requirements for Hormone Therapy for Adults

Reasons for Hormone Therapy. Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.

Eligibility Criteria. The administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist.

1. Age 18 years;
2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
3. Either:
   a. A documented real-life experience of at least three months prior to the administration of hormones; or
   b. A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 – for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

Readiness Criteria. Three criteria exist:

1. The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
2. The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality;
3. The patient is likely to take hormones in a responsible manner.

Can Hormones Be Given To Those Who Do Not Want Surgery or a Real-life Experience? Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

Hormone Therapy and Medical Care for Incarcerated Persons. Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

VIII. Effects of Hormone Therapy in Adults

The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and this cannot be overcome by increasing dosage. The degree of effects actually attained varies from patient to patient.

Desired Effects of Hormones. Biologic males treated with estrogens can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment.

Biologic females treated with testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

Potential Negative Medical Side Effects. Patients with medical problems or otherwise at risk for cardiovascular disease may be more likely to experience serious or fatal consequences of cross-sex hormonal treatments. For example, cigarette smoking, obesity, advanced age, heart disease, hypertension, clotting abnormalities, malignancy, and some endocrine abnormalities may increase side effects and risks for hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician.

Side effects in biologic males treated with estrogens and progestins may include increased propensity to blood clotting (venous thrombosis with a risk of fatal pulmonary embolism), development of benign pituitary prolactinomas, infertility, weight gain, emotional lability, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus.

Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability, increases in sexual desire, shift of lipid profiles to male patterns which increase the risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction.

The Prescribing Physician's Responsibilities. Hormones are to be prescribed by a physician, and should not be administered without adequate psychological and medical assessment before and during treatment. Patients who do not understand the eligibility and readiness requirements and who are unaware of the SOC should be informed of them. This may be a good indication for a referral to a mental health professional experienced with gender identity disorders.
The physician providing hormonal treatment and medical monitoring need not be a specialist in endocrinology, but should become well-versed in the relevant medical and psychological aspects of treating persons with gender identity disorders.

After a thorough medical history, physical examination, and laboratory examination, the physician should again review the likely effects and side effects of hormone treatment, including the potential for serious, life-threatening consequences. The patient must have the capacity to appreciate the risks and benefits of treatment, have his/her questions answered, and agree to medical monitoring of treatment. The medical record must contain a written informed consent document reflecting a discussion of the risks and benefits of hormone therapy.

Physicians have a wide latitude in what hormone preparations they may prescribe and what routes of administration they may select for individual patients. Viable options include oral, injectable, and transdermal delivery systems. The use of transdermal estrogen patches should be considered for males over 40 years of age or those with clotting abnormalities or a history of venous thrombosis. Transdermal testosterone is useful in females who do not want to take injections. In the absence of any other medical, surgical, or psychiatric conditions, basic medical monitoring should include: serial physical examinations relevant to treatment effects and side effects, vital sign measurements before and during treatment, weight measurements, and laboratory assessment. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

For those receiving estrogens, the minimum laboratory assessment should consist of a pretreatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pretreatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self-examination. As they age, they should be monitored for prostatic cancer.

For those receiving androgens, the minimum laboratory assessment should consist of pretreatment liver function tests and complete blood count with reassessment at 6 months, 12 months, and yearly thereafter. Yearly palpation of the liver should be considered. Females who have undergone mastectomies and who have a family history of breast cancer should be monitored for this disease.

Physicians may provide their patients with a brief written statement indicating that the person is under medical supervision, which includes cross-sex hormone therapy. During the early phases of hormone treatment, the patient may be encouraged to carry this statement at all times to help prevent difficulties with the police and other authorities.

Reductions in Hormone Doses After Gonadectomy. Estrogen doses in post-orchiectomy patients can often be reduced by 1/3 to ½ and still maintain feminization. Reductions in testosterone doses post-oophorectomy should be considered, taking into account the risks of osteoporosis. Lifelong maintenance treatment is usually required in all gender patients.

The Misuse of Hormones. Some individuals obtain hormones without prescription from friends, family members, and pharmacies in other countries. Medically unmonitored hormone use can expose the person to greater medical risk. Persons taking medically monitored hormones have been known to take additional doses of illicitly obtained hormones without their physician's knowledge. Mental health professionals and prescribing physicians should make an effort to encourage compliance with recommended dosages, in order to limit morbidity. It is ethical for physicians to discontinue treatment of patients who do not comply with prescribed treatment regimens.

Other Potential Benefits of Hormones. Hormonal treatment, when medically tolerated, should precede any genital surgical interventions. Satisfaction with the hormone's effects consolidates the person's identity as a member of the preferred sex and gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. In biologic males, hormones alone often generate adequate breast development, precluding the need for augmentation mammaplasty. Some patients who receive hormonal treatment will not desire genital or other surgical interventions.

The Use of Antiandrogens and Sequential Therapy. Antiandrogens can be used as adjunctive treatments in biologic males receiving estrogens, though they are not always necessary to achieve feminization. In some patients, antiandrogens may more profoundly suppress the production of testosterone, enabling a lower dose of estrogen to be used when adverse estrogen side effects are anticipated.

Feminization does not require sequential therapy. Attempts to mimic the menstrual cycle by prescribing interrupted estrogen therapy or substituting progesterone for estrogen during part of the month are not necessary to achieve feminization.

Informed Consent. Hormonal treatment should be provided only to those who are legally able to provide informed consent. This includes persons who have been declared by a court to be emancipated minors and incarcerated persons who are considered competent to participate in their medical decisions. For adolescents, informed consent needs to include the minor patient's assent and the written informed consent of a parent or legal guardian.

Reproductive Options. Informed consent implies that the patient understands that hormone administration limits fertility and that the removal of sexual organs prevents the capacity to reproduce. Cases are known of persons who have received hormone therapy and sex reassignment surgery who later regretted their inability to parent genetically related children. The mental health professional recommending hormone therapy, and the physician prescribing such therapy, should discuss reproductive options with the patient prior to starting hormone therapy. Biologic males, especially those who have not already reproduced, should be informed about sperm preservation options, and encouraged to consider banking sperm prior to hormone therapy. Biologic females do not presently have readily available options for gamete preservation, other than cryopreservation of fertilized embryos. However, they should be informed about reproductive issues, including this option. As other options become available, these should be presented.

IX. The Real-Life Experience

The act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience. The real-life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. Since changing one's gender presentation has immediate profound personal and social consequences, the decision to do so should be preceded by an awareness of what the familial, vocational, interpersonal, educational, economic, and legal consequences are likely to be. Professionals have a responsibility to discuss these predictable consequences with their patients. Change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children. These represent external reality issues that must be confronted for success in the new gender presentation. These consequences may be quite different from what the patient imagined prior to undertaking the real-life experiences. However, not all changes are negative.

Parameters of the Real-Life Experience. When clinicians assess the quality of a person's real-life experience in the desired gender, the following abilities are reviewed:

1. To maintain full or part-time employment;
2. To function as a student;
3. To function in community-based volunteer activity;
4. To undertake some combination of items 1-3;
5. To acquire a (legal) gender-identity-appropriate first name;

6. To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

Real-Life Experience versus Real-Life Test. Although professionals may recommend living in the desired gender, the decision as to when and how to begin the real-life experience remains the person's responsibility. Some begin the real-life experience and decide that this often imagined life direction is not in their best interest. Professionals sometimes construe the real-life experience as the real-life test of the ultimate diagnosis. If patients prosper in the preferred gender, they are confirmed as "transsexual," but if they decided against continuing, they "must not have been." This reasoning is a confusion of the forces that enable successful adaptation with the presence of a gender identity disorder. The real-life experience tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the mental health professional in their judgments about how to proceed. Diagnosis, although always open for reconsideration, precedes a recommendation for patients to embark on the real-life experience. When the patient is successful in the real-life experience, both the mental health professional and the patient gain confidence about undertaking further steps.

Removal of Beard and other Unwanted Hair for the Male to Female Patient. Beard density is not significantly slowed by cross-sex hormone administration. Facial hair removal via electrolysis is a generally safe, time-consuming process that often facilitates the real-life experience for biologic males. Side effects include discomfort during and immediately after the procedure and less frequently hypo-or hyper pigmentation, scarring, and folliculitis. Formal medical approval for hair removal is not necessary; electrolysis may be begun whenever the patient deems it prudent. It is usually recommended prior to commencing the real-life experience, because the beard must grow out to visible lengths to be removed. Many patients will require two years of regular treatments to effectively eradicate their facial hair. Hair removal by laser is a new alternative approach, but experience with it is limited.

X. Surgery

Sex Reassignment is Effective and Medically Indicated in Severe GID. In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.

How to Deal with Ethical Questions Concerning Sex Reassignment Surgery. Many persons, including some medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions, or alterations are made to body features to improve the patient's self image. Among those who object to sex reassignment surgery, these conditions are not thought to present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing

with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients discuss their life histories and dilemmas. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder.

It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.

The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional. The surgeon is not merely a technician hired to perform a procedure. The surgeon is part of the team of clinicians participating in a long-term treatment process. The patient often feels an immense positive regard for the surgeon, which ideally will enable long-term follow-up care. Because of his or her responsibility to the patient, the surgeon must understand the diagnosis that has led to the recommendation for genital surgery. Surgeons should have a chance to speak at length with their patients to satisfy themselves that the patient is likely to benefit from the procedures. Ideally, the surgeon should have a close working relationship with the other professionals who have been actively involved in the patient's psychological and medical care. This is best accomplished by belonging to an interdisciplinary team of professionals who specialize in gender identity disorders. Such gender teams do not exist everywhere, however. At the very least, the surgeon needs to be assured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with gender identity disorders. This is often reflected in the quality of the documentation letters. Since fictitious and falsified letters have occasionally been presented, surgeons should personally communicate with at least one of the mental health professionals to verify the authenticity of their letters.

Prior to performing any surgical procedures, the surgeon should have all medical conditions appropriately monitored and the effects of the hormonal treatment upon the liver and other organ systems investigated. This can be done alone or in conjunction with medical colleagues. Since pre-existing conditions may complicate genital reconstructive surgeries, surgeons must also be competent in urological diagnosis. The medical record should contain written informed consent for the particular surgery to be performed.

XI. Breast Surgery

Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. Although breast appearance is definitely important as a secondary sex characteristic, breast size or presence are not involved in the legal definitions of sex and gender and are not important for reproduction. The performance of breast operations should be considered with the

same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body.

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Female-to-male patients may have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

XII. Genital Surgery

Eligibility Criteria. These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");
3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
6. Awareness of different competent surgeons.

Readiness Criteria. The readiness criteria include:

1. Demonstrable progress in consolidating one's gender identity;
2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

Can Surgery Be Provided Without Hormones and the Real-life Experience? Individuals cannot receive genital surgery without meeting the eligibility criteria. Genital surgery is a treatment for a diagnosed gender identity disorder, and should undertaken only after careful evaluation. Genital surgery is not a right that must be granted upon request. The SOC provide for an individual approach for every patient; but this does not mean that the general guidelines, which specify treatment consisting of diagnostic evaluation, possible psychotherapy, hormones,

and real-life experience, can be ignored. However, if a person has lived convincingly as a member of the preferred gender for a long period of time and is assessed to be a psychologically healthy after a requisite period of psychotherapy, there is no inherent reason that he or she must take hormones prior to genital surgery.

Conditions under which Surgery May Occur. Genital surgical treatments for persons with a diagnosis of gender identity disorder are not merely another set of elective procedures. Typical elective procedures only involve a private mutually consenting contract between a patient and a surgeon. Genital surgeries for individuals diagnosed as having GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

Requirements for the Surgeon Performing Genital Reconstruction. The surgeon should be a urologist, gynecologist, plastic surgeon or general surgeon, and Board-Certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers. Surgeons should attend professional meetings where new techniques are presented.

Ideally, the surgeon should be knowledgeable about more than one of the surgical techniques for genital reconstruction so that he or she, in consultation with the patient, will be able to choose the ideal technique for the individual patient. When surgeons are skilled in a single technique, they should so inform their patients and refer those who do not want or are unsuitable for this procedure to another surgeon.

Genital Surgery for the Male-to-Female Patient. Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Other Surgery for the Male-to-Female Patient. Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals.
There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

Genital Surgery for the Female-to-Male Patient. Genital surgical procedures may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. Current operative techniques for

phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, the patient should be clearly informed that there are several separate stages of surgery and frequent technical difficulties which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one surgery. The plethora of techniques for penis construction indicates that further technical development is necessary.

Other Surgery for the Female-to-Male Patient. Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.

XIII. Post-Transition Follow-up

Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery. Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable, local, long-term aftercare in the patient's geographic region. Postoperative patients may also sometimes exclude themselves from follow-up with the physician prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any post-operative adjustment difficulties.

EXHIBIT C

STATE OF TEXAS §
§
DALLAS COUNTY §

AFFIDAVIT OF ERIC K. GORMLY

Before me, the undersigned notary, on this day personally appeared Eric K. Gormly, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

1. "My name is Eric K. Gormly. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

2. The Aetna Bulletin, marked herein as Exhibit A, and Harry Benjamin International Gender Dysphoria Association's Standards of Care, marked herein as Exhibit B, are exact photocopies of what they purport to be as seen on their respective websites as witnessed by myself."

Signature of Affiant

Sworn to and subscribed before me by Eric K. Gormly on October 5, 2011.

Notary Public

MATTHEW ROBERT DAVIS
Notary Public, State of Texas
My Commission Expires
June 30, 2015

EXHIBIT D

STATE OF TEXAS §
Galveston COUNTY §

AFFIDAVIT OF COLLIER M. COLE

Before me, the undersigned notary, on this day personally appeared Collier M. Cole, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

1. "My name is Collier M. Cole, Ph.D. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

2. "For over 30 years I have been a licensed clinical psychologist in the state of Texas. I am also a Clinical Full Professor in the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch, Galveston. I teach medical residents and medical students there on topics related to psychiatry and human sexuality. My area of specialty is in the diagnosis and treatment of sexual disorders. This includes the treatment of individuals/couples with sexual problems, treating individuals who are victims and perpetrators of sexual assault, and treating individuals with gender identity conditions. I am a member of a number of professional organizations, including the American Association of Sex Educators, Counselors, and Therapists, the American Psychological Association, the Texas Psychological Association, and the World Professional Association for Transgender Health (formally known as the Harry Benjamin International Gender Dysphoria Association). I have been a member of this latter organization since its inception in 1980. Over the years I have been involved in treating clients, educating students, and conducting clinical research on these topics. A full description of my professional activities can be found in the Curriculum Vita attached.

3. I personally have reviewed and edited the attached statement describing gender identity disorder, how it manifests itself, and treatments for those who have this condition. Specifically, I refer to what is marked below as Section G, paragraphs 1-16, and Section H, paragraphs 1-5. My comments following the text of these two sections."

G. THE MARRIAGE BETWEEN JAMES ALLAN SCOTT AND REBECCA LOUISE ROBERTSON IS NOT A SAME-SEX MARRIAGE: GENDER IDENTITY DISORDER AND TRANSSEXUALISM DESCRIBED

1. Petitioner maintains that the marriage between Ms. Robertson and Mr. Scott is void because it is a same-sex marriage. This claim fails to recognize transsexualism for what it is. Indeed, the overwhelming weight of scientific and behavioral evidence indicates it is patently false to claim that a transsexual man is actually a woman, or that a transsexual woman is actually a man. [1]

2. The many medical and research organizations that have conducted or compiled research into Gender Identity Disorder include, but are not limited to, the American Association of Sex Educators, Counselors, and Therapists; the American Psychological Association; the Texas Psychological Association; and the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association.

3. WPATH has long-established and internationally accepted Standards of Care (SOC) for the treatment of gender identity disorders. These are recognized and accepted by a number of psychological and medical entities, including the American Medical Association, the Texas Department of Health, and the Endocrine Society of the U.S. In addition, the Standards of Care have been updated and revised as new scientific information becomes available, and is currently in its sixth edition. Harry Benjamin International Gender Dysphoria Association's The Standards of Care for Gender Identity Disorders, Sixth Version (SOC), February 2001, http://www.wpath.org/publications_standards.cfm.

3. A leading expert in Gender Identity Disorder is Collier M. Cole, Ph.D., a licensed clinical psychologist in the state of Texas, and a Clinical Full Professor in the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch, Galveston.

4. Gender identity, according to Dr. Cole, is the personal private sense of being male or female. This usually but not always conforms to the genitals and other physical traits the person has. However, sexuality is complex, and is more a function of the brain than the genitals. In the case of someone with the condition known as Gender Identity Disorder (GID), formerly referred to as Gender Dysphoria, the person has longstanding and persistent feelings of being a member of the opposite sex, feelings that typically begin in early childhood. These feelings can and typically do lead to intense psychological conflict. This conflict results from the conviction that the person is one sex, but the person's body is the other. Without treatment as prescribed by the Standards of Care, this person will suffer intense psychological distress throughout life.

5. Research increasingly suggests that biological factors are behind GID, and recent scientific studies indicate that gender dysphoria may be related to a neuro-endocrine difference in the person's brain prior to birth, which can be distinct from genetics or anatomy. Sexuality is complex, involving chromosomes,

hormones, sexual anatomy, gender identity, sexual orientation, and sexual expression, among other underlying factors. All of these need to be taken into account, rather than simply relying on the male or female designation an attending physician or nurse makes during a quick exam of the infant's genitals – which may be mistaken. Sex is determined, not by what's between the legs, but by what's between the ears.

6. In 1980, the Harry Benjamin International Gender Dysphoria Association established the first so-called Standards of Care. SOC, 2001. The person with GID must undergo extensive psychological evaluation and therapy. The central method used to confirm a diagnosis of gender dysphoria consists of the "real life experience." Lasting a minimum of a year, the person undergoes hormone therapy to become more male or female in appearance, and lives and works fulltime in the adopted gender role. During this time, the therapist works in coordination with the patient's physician. Once the real life experience is complete and the therapist confirms as much, the person can change his or her name, change gender designations on identity documents and so on. Following a successful transition, an individual may pursue gender reassignment surgery to reform the body, including reconstructing the genitals, to appear more like the person perception of self.
7. There also are certain conditions stemming from chromosomal anomalies, such as XXY, 46XY, 46XX, or 47XY chromosome sequences. Also, anatomical anomalies, such as intersex conditions, are not uncommon. In these cases, physicians are urged not intervene until the person old enough to accept his or her gender identity. As with gender dysphoria, the person can undergo surgical and medical procedures to line up that person's body to fit the mind. This completes the treatment and resolves the underlying issue.
8. Dr. Cole maintains there is no "cure" for this condition, and he sees the fact that the physical apparent sex fails to match the psychological sex as a sort of birth defect. The treatment is to counsel the person on how to adjust, prescribe hormone therapy, and have them carry out the "real life experience." During this period, through continued counseling, the therapist and physicians can determine if the person is an appropriate candidate for fulltime living in the chosen gender and for sexual reassignment surgery.
9. In addition to psychological distinctions, research indicates that the physical brain of a transsexual may be different and function differently from the typical brain of someone with a gender identity that conforms to that person's general physical traits. Many aspects of sexuality exist more in the grey matter than in the anatomical parts that typically distinguish male from female. Transsexualism as an intense discomfort with one's gender assignment as designated at birth, leading to an intense conflict the person experiences from his or her psychological sex not matching the body he or she inhabits. This is not a choice, and there is no "cure" for Gender Identity Disorder. The treatment is working with the patient to bring his or her body more in line with his or her brain. The

process of evaluating GID and monitoring the regimen involved in a transsexual's transition is a painstaking, exacting and irreversible one, lasting anywhere from one to two years.

10. There is a clear and definite distinction between transsexualism and homosexuality. Transsexuality applies to the feeling that someone has about him or herself, such as, "Am I comfortable being a man," or "Do I feel like a woman even though I have a male body?" Sexual orientation – heterosexuality, bisexuality or homosexuality – refers to who a person is attracted to: men, women or both. Sexual orientation refers to relationships with others. Gender identity refers to the relationship with one's self.

11. Sexual orientation is separate from gender identity, and typically does not change following transition. Once the person completes the reassignment from female to male, that transsexual man who is attracted to women should be considered heterosexual. Furthermore, that person is highly unlikely to have considered himself a lesbian prior to transition.

12. The sexual reassignment surgery is extensive and irreversible. For the female to male transsexual, following the year-long "real life experience," the patient goes through surgery to remove the uterus, ovaries, and fallopian tubes, known as "bottom surgery," and to remove the breasts, known as "top surgery."

13. A procedure called phalloplasty, which is the creating of an appendage meant to resemble a male penis, is one option a transsexual man can have performed. However, many medical and psychological professionals recommend against it, and many patients go with other options. The phalloplasty technique takes muscle tissue from the arm or other part of the body, then attempts to form the tissue into a tube-shaped appendage that is surgically attached to the pubic area. Complications with this procedure include leaving a deformity where the tissue is taken, a scar, a long and painful recovery, risk of infection, and risk of loss of the limb's full function. An additional complication is that the appendage does not fully look like a penis, does not function like one in terms of sexual activity (it requires an implant to achieve an erection), and largely lacks sensation. Further complications can include urinary tract infections, urinary tract obstructions, risk of renal failure, or the need to wear a Foley catheter. In a common complication, sections of the phallus tissue itself can die and slough off or need to be surgically removed. Finally, the surgery is extremely expensive.

14. However, a clitoris is actually quite similar in structure to the penis. Just as testes and ovaries begin as the same group of cells in a developing fetus, so do the penis and the clitoris. After extended exposure to testosterone during transition, the clitoris will begin to enlarge until it reaches and maintains the size and appearance of a small penis. Furthermore, the clitoris contains the same sort of tissues as the penis, and thus will respond to sexual stimulation as the penis does by swelling, extending and becoming erect. As a result, many female to

male transsexuals decide against a phalloplasty, instead allowing the clitoris to develop from the testosterone.

15. With the clitoris permanently enlarged on testosterone, transsexual men can later opt for a procedure known as metoidioplasty, also known as a "clitoral release." Compared to a phalloplasty, this is a relatively simple, low-cost and low-risk surgery that enables the newly developed "penis" to extend farther.

16. But therapists who work with transgendered clients consider neither a phalloplasty nor a metoidioplasty necessary to achieve "completion" of the transition for a female to male transsexual. Rather, after completing the "real life experience," completing the psychological therapy and hormone therapy, and undergoing surgeries to remove the breasts, ovaries, fallopian tubes and uterus, that person is considered a fully transitioned transsexual man.

H. JAMES ALLAN SCOTT IS AND SHOULD BE RECOGNIZED AS A MAN FOR ALL LEGAL PURPOSES

1. In Mr. Scott's case, at a young age, he experienced the same feelings of being the opposite sex of the gender he had been assigned at birth, feelings that continued and strengthened throughout his life. Although born with a female anatomy, Mr. Scott considered himself to be, not a lesbian woman, but a heterosexual man with the wrong body.

2. Mr. Scott underwent all of the necessary evaluations, which found him to be psychologically male. He underwent the full regimen of procedures in following the Standards of Care as prescribed by WPATH, including long-term therapy, testosterone therapy, and living full time as a man, or the "real life experience." Ultimately, Mr. Scott had irreversible surgeries performed to more fully enable him to live his life as a man. Specifically, the series of surgeries was performed on Mr. Scott to remove his breasts, ovaries, fallopian tubes and uterus. He decided against a phalloplasty, opting instead to pursue a metoidioplasty.

3. Mr. Scott petitioned Dallas County District Court for a change of name and sex designation, supplying the necessary documents to do so. On March 13, 1998, the court granted an order that his name and gender marker be appropriately changed. Mr. Scott then presented the full set of documentation required by the state of Iowa for a new birth certificate, which included verification of evaluation for Gender Identity Disorder, psychological therapy, recommendation to transition, real life experience, hormone therapy, and the irreversible sexual reassignment surgery. After reviewing the proper documentation, the state of Iowa issued Mr. Scott a new birth certificate.

4. In light of the previous discussion, Mr. Scott rebuts a number of "facts" the Petitioner asserts in her brief. Female gender is not "universally determined" by looking at genitalia, as stated by Petitioner in Fact 4.B. Indeed, without any legal test for what determine a man or a woman for the purpose of marriage, Petitioner has no grounds to apply her own definition of female or claim a

"universally determined" standard in doing so. Facts 4.A. and 4.B. In addition, by asserting that Mr. Scott has failed to complete the medical procedures that "would provide her [sic] with male genitalia," Petitioner shows a lack of understanding of the current state of medical technology relating to sexual reassignment surgery for a female-to-male transsexual. No procedure exists that could do so safely or effectively, and, in fact, would get in the way of sexual function and pose a potentially dangerous health risk.

5. By the same measure, Petitioner has no grounds, as she asserts in Fact 4.E., to determine what are the "universally accepted attributes of a male," nor can she claim that Mr. Scott lacks such characteristics. Petitioner claims these "universally accepted attributes" consist of "a penis, scrotum or testicles." Mr. Scott rejects that statement, as do many health care professionals who deal with sexual issues.

4. "Regarding Section G above, I can attest that this statement is a an accurate and balanced discussion, and endorse its contents. Similarly with Section H above, this description of Mr. James Scott's experiences fit completely with those of a transsexual man, and this section describes what a transsexual man would need to do to fully transition. Finally, based on my experience in this area, I challenge the notion that the existence or absence of the male genitalia described define universally accepted attributes or characteristics of a male. Based on what has been described here, Mr. Scott would have to be considered a fully transitioned transsexual man."

Collier M. Cole, Ph.D.

Collier M. Cole, Ph.D.

Sworn to and subscribed before me by Collier M. Cole, Ph.D., on October 5, 2011.

Phyllis K. Hosey

Notary Public in and for the State of Texas

PHYLLIS K. HOSEY NOTARY PUBLIC STATE OF TEXAS EXPIRES 04-15-2012

EXHIBIT E

CURRICULUM VITAE

NAME: Collier M. Cole, Ph.D. **DATE:** September 2011

PRESENT POSITIONS AND ADDRESSES:

Clinical Professor
Department of Psychiatry and Behavioral Sciences
School of Medicine
The University of Texas Medical Branch
Galveston, Texas 77555-0188

Clinical Professor
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BIOGRAPHICAL:

Birthplace:	Burbank, California
Birthdate:	December 6, 1949
Marital Status:	Married
Home Address:	2905 Cottonwood Drive Dickinson, Texas 77539 (281) 534-4939

EDUCATION:

1976	Ph.D.	University of Houston Houston, Texas Major in Clinical Psychology (APA Approved)
1973	M.A.	University of Houston Houston, Texas Major in Clinical Psychology (APA Approved)
1971	B.A.	University of California at Los Angeles Los Angeles, California Major in Psychology (Cum Laude)

PROFESSIONAL AND TEACHING EXPERIENCE:

1998 – Present	Clinical Professor Department of Psychiatry and Behavioral Sciences School of Medicine The University of Texas Medical Branch Galveston, Texas
1998 – Present	Clinical Professor Department of Physician Assistant Studies School of Health Professions The University of Texas Medical Branch Galveston, Texas
1993 - 1995	Consulting Clinical Psychologist Life Elements-Community based Treatment for Adults with Brain Injuries 11914 Astoria Boulevard, Suite 490 Houston, Texas 77089
1992 – 1998	Clinical Associate Professor Department of Psychiatry and Behavioral Sciences School of Medicine The University of Texas Medical Branch Galveston, Texas
1991 - 1992	Consulting Clinical Psychologist Memorial Institutes of Physical and Rehabilitative Medicine Memorial Southeast Hospital Houston, Texas
1985 – 1998	Clinical Associate Professor Department of Physician Assistant Studies School of Allied Health Sciences The University of Texas Medical Branch Galveston, Texas
1980 - 1992	Clinical Assistant Professor Department of Psychiatry and Behavioral Sciences School of Medicine The University of Texas Medical Branch Galveston, Texas

PROFESSIONAL AND TEACHING EXPERIENCE continued:

1985 - 1991	Consulting Clinical Psychologist Transitional Learning Community (A residential rehabilitation facility for brain injured individuals) 1528 Postoffice Street Galveston, Texas
1980 - 1985	Mental Health Consultant Galveston County Head Start Programs Galveston, Texas
1979 - 1985	Assistant Professor Department of Physician Assistant Studies School of Allied Health Sciences The University of Texas Medical Branch Galveston, Texas
1979	Assistant Professor Department of Psychiatry and Behavioral Sciences School of Medicine The University of Texas Medical Branch Galveston, Texas
1979	Instructor Division of Cardiology Department of Internal Medicine School of Medicine The University of Texas Medical Branch Galveston, Texas
1977 - 1979	Instructor Department of Psychiatry and Behavioral Sciences School of Medicine The University of Texas Medical Branch Galveston, Texas
1976 -1979	Instructor Department of Health Care Sciences School of Allied Health Sciences The University of Texas Medical Branch Galveston, Texas

PROFESSIONAL AND TEACHING EXPERIENCE continued:

1976 - 1977	Post-Doctoral Fellow Division of Community and Social Psychiatry Department of Psychiatry and Behavioral Sciences The University of Texas Medical Branch Galveston, Texas
1975 - 1976	Clinical Psychology Intern Department of Psychiatry and Behavioral Sciences The University of Texas Medical Branch Galveston, Texas (APA Approved)
1973 - 1975	Teaching Fellow Department of Psychology University of Houston Houston, Texas

RESEARCH ACTIVITIES:

Medical-Psychosocial Treatment Outcome for Gender Identity Disorder (Transsexualism)

Evaluation of Treatment Outcome for Paraphilic Disorders (Sexually offending behaviors)

Sexual Adjustment following Traumatic Brain Injury

COMMITTEE RESPONSIBILITIES:
UTMB:

1989 - 2003	Member, Clinical Psychology Internship Training Team School of Allied Health Sciences (APA Approved) Program voluntarily placed on "inactive" status
1976 - 1998	Member, Admissions Committee Department of Physician Assistant Studies School of Allied Health Sciences

Other:

1984 - 1998	Member, Council on Sex Offender Treatment, State of Texas. Appointed by the Governor (approved by Texas Legislature) to a council designed to assess and recommend treatment and educational services to combat problems of sexual abuse; served three appointed terms. Elected to position of Chairman annually for last seven years, serving as spokesperson for Council on relevant issues.

COMMITTEE RESPONSIBILITIES continued:

1998 – Present	Member, Clinical Issues Committee, Council on Sex Offender Treatment, State of Texas. Appointed to committee which advises Council on issues related to management strategies to combat sex offending behavior and reduce victimization.

TEACHING RESPONSIBILITIES AT UTMB:

2001 – 2010	Instructor Department of Obstetrics and Gynecology Medical Student Clerkship Program (Lectures on Sexual Disorders)
1993- Present	Instructor Department of Psychiatry and Behavioral Sciences Core Curriculum Lecture Series to Psychiatry residents (Series of lectures on Sexual Disorders)
1989 – 2003	Member, Clinical Psychology Internship Training Team (APA Approved) School of Allied Health Sciences (Series of lectures on Sexual Disorders)
1981 - Present	Secondary Instructor Department of Humanities and Basic Sciences School of Health Professions (Course entitled Promoting Sexual Health and Rehabilitation)
1976 – 1998	Primary Instructor and Small Group Leader Department of Physician Assistant Studies School of Allied Health Sciences (Human Dynamics I - Techniques in Medical Interviewing) (Human Dynamics II - Introduction to Psychiatry) (Human Dynamics III - Techniques in Patient Education)

MEMBERSHIP IN SCIENTIFIC SOCIETIES:

Association for the Treatment of Sexual Abusers (1993-Present)
Harry Benjamin International Gender Dysphoria Association, now called World Professional Association for Transgender Health (1980-Present)

MEMBERSHIP IN SCIENTIFIC SOCIETIES continued:

Texas Psychological Association (1978-Present)
American Psychological Association (1978-Present)
American Association of Sex Educators, Counselors, and Therapists (1977-Present)

CERTIFICATION:

Licensed Health Service Provider (National Register of Health Service Providers in Psychology, Washington, DC, No. 17702); 1979-Present

Licensed Clinical Psychologist (Texas State Board of Examiners of Psychologists, No. 2-1900); 1979-Present

Certified Diplomate in Sex Therapy (American Association of Sex Educators, Counselors, and Therapists, Richmond, Virginia); 1978-Present

Certified Sexuality Educator (American Association of Sex Educators, Counselors, and Therapists, Richmond, Virginia); 1978-Present

Licensed Sex Offender Treatment Provider - LSOTP
(Council on Sex Offender Treatment, Austin, Texas); 1991-Present

HOSPITAL APPOINTMENTS:

1984 - Present	Part-time Consulting Membership on Medical Staff The University of Texas Medical Branch Hospitals
1985 - 1996	Allied Health Professional/Psychologist Privileges St. Mary's Hospital, Galveston

HONORS

1976 – 1977	Post-Doctoral Fellow Division of Community and Social Psychiatry Department of Psychiatry and Behavioral Sciences The University of Texas Medical Branch Galveston, Texas
1975 - 1976	Internship in Clinical Psychology (APA Approved) Department of Psychiatry and Behavioral Sciences The University of Texas Medical Branch Galveston, Texas

HONORS continued:

1973 - 1975	Teaching Fellowship (University of Houston)
1973 - 1974	Veterans Administration Traineeship (V.A. Hospital, Houston, Texas)
1971 - 1973	NIMH Traineeship

ADDITIONAL INFORMATION:

Teaching Responsibilities Outside UTMB:

1983 - Present	Lecturer Department of General Academics Texas A & M University Galveston, Texas (Annual undergraduate courses in Introductory Psychology and Abnormal Psychology)
1985 – 1991	Clinical Training Faculty Clinical Psychology Internship Program (APA Approved) Baylor College of Medicine, Houston (Supervisor of interns during 12 month rotations at Transitional Learning Community, Galveston)
1984 - 1986	Lecturer Officer Training Program Galveston Police Academy Galveston, Texas (Topics in psychopathology, sexual disorders and deviations)
1977 - 1985	Lecturer Behavioral Sciences Program University of Houston at Clear Lake (Graduate courses in behavioral medicine, human sexuality, psychotherapy, childhood psychopathology; undergraduate courses in human sexuality and adolescent psychology)

BIBLIOGRAPHY PUBLISHED:

A. ARTICLES IN PEER-REVIEWED JOURNALS

1998 Walling, D., Goodwin, J., and Cole, C. "Dissociation in a Transsexual Population." Journal of Sex Education and Therapy, 1998, 23(2), 121-23.

1997 Meyer, W. and Cole, C. "Physical and Chemical Castration of Sex Offenders: A Review." Journal of Offender Rehabilitation, 1997, 25 (3/4), 1-18.

1997 Cole, C., Cory, D., McKenzie, C., May, E., and Meyer, W. "Policy Development for the Control of Sex Offending Behavior." Texas Medicine, 1997, 93 (3), 65-69.

1997 Schmitz, B., Cole, C., Baker, J., and Berton, M. "Instructing PA Students with Interactive Videoconferencing." Physician Assistant, 1997, 21 (6), 143-147.

1997 Lundgren, S., Cole, C., and Meyer W. "A Preliminary Survey of Texas Registered Sex Offender Treatment Providers' Efforts to Track Treatment Failures." Texas Probation, 1997, 12 (1), 2-5.

1997 Cole, C., O'Boyle, M., Emory, L., and Meyer, W. "Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses." Archives of Sexual Behavior, 1997, 26(1), 13-26.

1995 Emory, L., Cole, C., and Meyer, W. "Use of Depo-Provera to Control Sexual Aggression in Persons with Traumatic Brain Injury." Journal of Head Trauma Rehabilitation, 1995, 10 (3), 47-58.

1994 Cole, C., Emory, L., Huang, T., and Meyer, W. "Treatment of Gender Dysphoria or Transsexualism." Texas Medicine, 1994, 90(5), 68-72.

1992 Meyer, W., Cole, C., and Emory, L. "Depo-Provera Treatment for Sex Offending Behavior: An Evaluation of Outcome." Bulletin of the American Academy of Psychiatry and the Law, 1992, 20(3), 249-259.

1992 Emory, L., Cole, C., and Meyer, W. "The Texas Experience with Depo-Provera: 1980-90." Journal of Offender Rehabilitation, 1992, 18(3,4), 125-139.

1992 Meyer, W., Wiener, I., Emory, L., Cole, C., Isenberg, N., Fagan, C., and Thompson, J. "Cholelithiasis Associated with Medroxyprogesterone Acetate Therapy in Men." Research Communications in Clinical Pathology and Pharmacology, 1992, 75(1), 69-84.

BIBLIOGRAPHY PUBLISHED Articles in Peer-reviewed Journals: continued

1991 Emory, L., Williams, D., Cole, C., Amparo, E., and Meyer, W. "Anatomic Variations of the Corpus Collosum in Persons with Gender Dysphoria." Archives of Sexual Behavior, 1991, 20(4), 409-417.

1981 Chesney, A., Blakeney, P., Chan, F., and Cole, C. "The Impact of Sex Therapy on Sexual Behaviors and Marital Communication." Journal of Sex and Marital Therapy, 1981, 7(1), 70-79.

1980 Cole, C., Chan, F., Blakeney, P., and Chesney, A. "Participants' Reactions to Components of a Rapid-Treatment Workshop for Sexual Dysfunction." Journal of Sex and Marital Therapy, 1980, 6(1), 30-39.

1979 Cole, C. "A Treatment Strategy for Postmyocardial Sexual Dysfunctions." Sexuality and Disability, 1979, 2(2), 122-129.

1979 Cole, C., Blakeney, P., Chan, F., Chesney, A., and Creson, D. "The Myth of Symptomatic versus Asymptomatic Partners in the Conjoint Treatment of Sexual Dysfunction." Journal of Sex and Marital Therapy, 1979, 5(2), 79-89.

1979 Cole, C., Levin, E., Whitley, J., and Young, S. "Brief Sexual Counseling During Cardiac Rehabilitation." Heart and Lung, 1979, 8(1), 124-129.

1978 Cole, C. "The Role of Brief Family Therapy in Medical Rehabilitation." Journal of Rehabilitation, 1978, 44(4), 29-31, 42.

B. Other

2000 Cole, C., Voyles, L., and Zapata, L. "Building Victim Empathy into Sex Offender Treatment." Texas Resource, The Official Newsletter of the Council on Sex Offender Treatment, 2000, 8(1), 8.

1998 Cole, C. and Meyer, W. "Transgender Behavior and DSM IV." In Denny, D. (Ed.). Current Concepts in Transgender Identity: Towards a New Synthesis. Garland Publishers, New York, 1998.

1996 Cole, C. "An Approach to Patient Education." In Muma, R., Lyons, B., Newman, T., and Carnes, B. (Eds.). Patient Education: A Practical Approach. Appleton and Lange, Stamford, Connecticut, 1996.

BIBLIOGRAPHY PUBLISHED: OTHER continued

1996 Cole, C. "Psychiatry." In Rahr, R. and Niebhur, B. (Eds.). Physician Assistant Examination Review (Third Edition). Appleton and Lange, Stamford, Connecticut, 1996.

1991 Cole, C. "Psychiatry." In Rahr, R. and Niebhur, B. (Eds.). Physician Assistant Examination Review (Second Edition). Medical Examination Publishing Company, New York, 1991.

1985 Hoek, B., Cole, C., and Rosenfeld, B. "Common Sexual Concerns in the Office Setting: A Systemic Approach." In Henao, S. and Grose, N. (Eds.). Principles of Family Systems in Family Medicine. Brunner-Mazel Publishers, New York, 1985.

1983 Cole, C., "Sexual Disorders and the Family Therapist." In Hansen, J., Woody, J., and Woody R. (Eds.). Sexual Issues in Family Therapy. Aspen Systems Corporation, Rockville, Maryland, 1983.

1982 Cole, C. and Blakeney, P. "Understanding Sexuality in the Aged." Paper published in the symposium proceedings of Aging in America: Current Issues, The University of Texas Medical Branch, April.

1980 Cole, C., and Young, S. "Comprehensive Medical-Psychosocial Management of the Post-myocardial Infarction Patient." In Czerwinski, B. (Ed.). A Manual of Patient Education for Cardiopulmonary Dysfunctions. C.V. Mosby Company, St. Louis, 1980.

1980 Worley, K.J., Henson, E.I., and Cole, C. "Sexual Activities and the Cardiac Surgery Patient." In Czerwinski, B. (Ed.). A Manual of Patient Education for Cardiopulmonary Dysfunctions. C.V. Mosby Company, St. Louis, 1980.

1979 Cole, C. "Psychological Aspects in Cardiac Rehabilitation." Self-instructional Unit, Health Sciences Consortium, Chapel Hill, North Carolina, 1979.

1978 Cole, C. "Myths Regarding Sexuality and Old Age." Published in the symposium proceedings of Enhancing Health and Lifestyles for the Aging, The University of Texas Medical Branch, September.

1974 Cole, C., Martin, S., and Vincent, J. "A Comparison of Two Teaching Formats at the College Level." In Johnston, J. (Ed.). Research and Technology in Higher Education-Individualized Instruction. Charles C. Thomas, Springfield, Illinois, 1974.

PROFESSIONAL PRESENTATIONS AND ABSTRACTS
(Those which are peer-reviewed and selected are noted by*)

2011 Cole, C. "Sex Offender Treatment in the Criminal Justice System." Presented to the Brazoria County Bar Association, Angleton, Texas, September.

2007 Cole, C. "Understanding Gender Identity Disorder." Presentation to the Houston Section of the American Association of the Sex Educators, Counselors, and Therapists, Houston, Texas, September.

2006 Cole, C., Emory, L., and Swartz, J. "Reducing Sexual Violence Through Treatment and Management of The Adult Sex Offender." Workshop presented at the Legislative Conference of the Texas Probation Association, Galveston, Texas, August.

2004 Cole, C. and Davis, G. "Ethical Issues in the Supervision and Treatment of the Juvenile Offender." Workshop presented at the Twelfth Annual Conference on Juveniles with Sexual Behavior Problems, San Antonio, Texas, July *

2004 Meyer, W., Emory, L., and Cole, C. "Gender Dysphoria: Current Approaches, Standards of Care, and Outcome Studies." Presentation to the Department of Psychiatry and Behavioral Sciences Grand Rounds Series, University of Texas Medical Branch, Galveston, Texas, January.

2003 Emory, L., Cole, C., Avery, E., and Meyer, W. "Client's Views of Gender Identity: Life, Treatment Status, and Outcome." Paper presented at the Eighteenth Harry Benjamin International Gender Dysphoria Symposium, Gent, Belgium, September.*

2003 Cole, C. "Key Issues in the Treatment and Supervision of Adult Sex Offenders." Workshop presented at the Texas Probation Association's Legislative Conference, Galveston, Texas, August.*

2003 Cole, C. "Working with the Sex Offender." Half-day workshops presented to the training staff at the Gulf Coast Center, Galveston (March), and the training staff at Brazos Place Substance Abuse Recovery Center, Freeport (March).

2002 Davis, G. and Cole, C. "Sexual Assault and the Law: Impact on Survivors and Offenders." Workshop presented at the 22nd Annual Texas Association Against Sexual Assault Conference, San Antonio, Texas, March.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

2002 Cole, C. and Davis, G. "Sexual Assault and the Law: Impact on Survivors and Offenders." Workshop presented at the Tenth Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, Corpus Christi, Texas, February.*

2001 Picard, T., Emory, L., and Cole, C. "Transsexuality and the Current Law." Paper presented at the Seventeenth Harry Benjamin International Gender Dysphoria Symposium, Galveston, Texas, November.*

2001 Cole, C. "Key Issues in Sex Offender Intervention: The Law, Community Supervision, and Treatment." Workshop presented at the Fifteenth Annual Skills for Effective Intervention Conference, Texas Department of Criminal Justice – Community Justice Assistance Division, Austin, Texas, July.*

2001 Cole, C., "Treatment of Adult Sex Offenders in the Community" and "Medications Used as an Adjunct to Sex Offender Treatment." Workshops presented at conference entitled "Sexual Assault in Texas: From Outcry to Sex Offender Management and Community Healing." Sponsored by the Office of the Attorney General, Austin, Texas, April.

2001 Cole, C., and Criss, S. "Special Concerns in the Treatment and Supervision of Adult Sex Offenders." Workshop presented at Texas Probation Association Regional Conference, Galveston, Texas, January.*

2000 Cole, C. "Multidisciplinary Treatment of Gender Dysphoria or Transsexualism." Workshop presented at the Texas and Oklahoma Psychological Associations' Joint Annual Conference, Dallas, Texas, September.*

2000 Cole, C. "Updates in the Law on Sex Offender Supervision." Workshop presented at the Fourteenth Annual Skills for Effective Intervention Conference, Texas Department of Criminal Justice – Community Justice Assistance Division, Austin, Texas, June.*

1998 Cole, and Davis, G. "Reducing Sexual Violence Through Community-Based Treatment of Offenders – We Can Do It Together." Workshop presented at First National Sexual Violence Prevention Conference, Dallas, Texas, May.*

2000 Cole, C., Emory, L., Collins, D., Swartz, J., Voyles, L., and Zapata, L. "Community-Based Multidisciplinary Treatment of Adult Sex Offenders." Workshop presented at the Eighth Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, Addison, Texas, February.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1999 Davis, G. and Cole, C. "Bringing It Together: Treatment Providers and Victim Services in the Next Century." Workshop presented at the SSSS/AASECT Joint Annual Conference, St. Louis, Missouri, November.*

1999 Cole, C. "Resuming Sexuality Following Traumatic Brain Injury." Workshop presented at the Brain Injury Association of Texas Annual State Conference, Houston, Texas, August. *

1999 Cole, C. "The Law on Sex Offender Supervision." Workshop presented at the Thirteenth Annual Skills for Effective Intervention Conference, Texas Department of Criminal Justice – Community Justice Assistance Division, Austin, Texas, May.*

1999 Cole, C., Davis, G., Collins, D., Voyles, L., Zapata, L., and Swartz, J. "Dealing with Sex Offenders at the Community Level: A Collaborative Approach, Parts 1 and 2." Workshop presented at the 20th Annual Texas Association Against Sexual Assault Conference, Austin, Texas, March. *

1999 Cole, C. "Special Concerns Involved in Gender Dysphoria or Transsexualism." Keynote address at conference entitled "The Complexity of Sexual Identity" sponsored by Campus Ministries Association and the University of Houston, Houston, Texas, March.

1999 Cole, C. and Davis, G. "Prevention of Child Sexual Abuse through Interventions with Offenders: Parts 1 and 2." Workshop presented at the Thirteenth Annual Governor's Conference on the Prevention of Child Abuse, Austin, Texas, January. *

1998 Cole, C. "Sex Offenders: Identification and Treatment." Workshop presented at conference on "Sexual Assault: Issues and Answers Training" sponsored by the Multi-County Interagency Coalition Against Sexual Assault (MICSA), Alvin, Texas, November.

1998 Cole, C., Cory, D., and Meyer, W. "Participating in Public Policy Development for the Management of Sex Offenders: The Texas Council on Sex Offender Treatment." Workshop presented at the Seventeenth Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Vancouver, British Columbia, Canada, October. *

1998 Cole, C. "The Law on Sex Offender Supervision." Workshop presented at the Annual Skills for Effective Intervention Conference, Texas Department of Criminal Justice - Community Justice Assistance Division, Austin, Texas, June. *

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1998 Cole, C. "The Sex Offender – Treatment and Punishment." Invited workshop presented at the Third Annual Seminar of the Houston-Harris County Interagency Council on Sexual Assault, Houston, Texas, April.

1998 Cole, C. and Davis, G. "Sex Offending Myths: Do You Know the Truth?" (Parts 1 and 2). Invited workshops presented at the 19th Annual Texas Association Against Sexual Assault Conference, Laredo, Texas, March. *

1998 Cole, C. "Sexual Abuse – Victims and Perpetrators." Invited inservice workshop presented to professional staff of the Gulf Coast Center (MHMR), Galveston, Texas, February.

1997 Cole, C., Emory, L. and Meyer, W. "Medications used in Treatment of Sex Offenders." Workshop presented at the Sixth Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, Huntsville, Texas, November. *

1997 Avery, E., Cole, C., and Meyer, W. "A Survey of Gender Clinics and Surgeons Regarding Current Treatment Services for HIV+ Individuals." Paper presented at the Fifteenth Harry Benjamin International Gender Dysphoria Symposium, Vancouver, British Columbia, Canada, September. *

1997 Avery, E., Paar, D., Cole, C., and Meyer, W. "The Effect of Estrogen on Hepatic Transaminases in Male-to-Female Transsexuals with Chronic Viral Hepatitis." Poster presented at the Fifteenth Harry Benjamin International Gender Dysphoria Symposium, Vancouver, British Columbia, Canada, September. *

1997 Cole, C. and Davis, G. "Sex Offender Treatment: A Key Element in Reducing Sexual Violence." Invited workshop presented at 18th Annual Texas Association Against Sexual Assault Conference, Austin, Texas, February.

1996 Cole, C. "Treatment of Gender Dysphoria or Transsexualism." Presentation to the Department of Psychiatry and Behavioral Sciences Lecture Series, University of Texas - Houston Health Science Center, Houston, Texas, November.

1996 Cole, C., Collins, D., O'Brien, J., and McMurrey, C. "Rehabilitating the Sex Offender: Treatment and Community Supervision Perspectives." Workshop presented at the Annual Meeting of the Society for the Scientific Study of Sexuality (SSSS), Houston, Texas, November.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1996 Avery, E., Cole, C., and Meyer, W. "Transsexuals and HIV/AIDS Risk Behaviors." Paper presented at the Annual Meeting of the Society for the Scientific Study of Sexuality (SSSS), Houston, Texas, November.*

1996 Dott, S. Walling, D., Cole, C., and Meyer, W. "Schizophrenia and Gender Dysphoria: Misdiagnosis, Misconceptions, and Realities." Paper presented at the Annual Meeting of the Society for the Scientific Study of Sexuality (SSSS), Houston, Texas, November.*

1996 Cole, C. "Sexual Predators and Offenders." Workshop presented at conference on "Sexual Assaults, Predators, Myths, Laws, and Victims" sponsored by the Temple Police Department and Bell County Crime Victims Coalition, Temple, Texas, October.

1996 May, E., Cole, C., and Meyer, W. "Moving Ahead into the 21st Century: Offender Treatment and Its Impact on Communities." Workshop presented at the Annual Community MHMR Centers Staff Training Conference, Galveston, Texas, July.*

1996 May, E., Cory, D., and Cole, C. "Texas Legislative Efforts for Sex Offender Treatment as a Deterrent to Criminal Sexual Assault of Children." Workshop presented at the Sixth Annual Texas Forensic Mental Health Conference, Vernon State Hospital, Vernon, Texas, April.*

1996 Cole, C. and May, E. "Child Sexual Abuse: Pedophiles." Invited workshop presented at 17th Annual Texas Association Against Sexual Assault Conference, Galveston, Texas, February.

1996 Cole, C., May, E., and Lewis-Heine, V. "Legislative Efforts for Sex Offender Treatment as Deterrent to Criminal Sexual Assault of Children." Workshop presented at 10th Annual Governor's Conference on the Prevention of Child Abuse, Austin, Texas, January.*

1995 Dott, S., Walling, D., Avery, E., Cole, C., and Meyer, W. "Schizophrenia and Transsexualism: Defining the Boundaries." Paper presented at the Fourteenth Harry Benjamin International Gender Dysphoria Symposium, Kloster Irsee, Bavaria, Germany, September.*

1995 Walling, D., Goodwin, J., and Cole, C. "Dissociation and Gender Dysphoria: Exploring the Relationship." Paper presented at the Fourteenth Harry Benjamin International Gender Dysphoria Symposium, Kloster Irsee, Bavaria, Germany, September.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued

1995 Avery, E., Cole, C., and Meyer, W. "Transsexuals and HIV/AIDS Risk Behaviors." Poster presented at the Fourteenth Harry Benjamin International Gender Dysphoria Symposium, Kloster Irsee, Bavaria, Germany, September.*

1995 Cole, C., May, E., and Lewis-Heine, V. "Sexual Abuse: Treating Victims and Perpetrators." Workshop presented at The Tenth Annual Governor's Training Conference on Victim Assistance, Austin, Texas, August.*

1995 McMurrey, C., Cole, C., Emory, L., and O'Brien, J. "A Team-Based Model for the Assessment and Treatment of Adult Sex Offenders: A Treatment and Supervision Collaboration." Workshop presented at the Texas Probation Association 1995 Legislative Conference, Austin, Texas, August. *

1995 Cole, C., "Transgender Behavior and DSM IV." Paper presented at the Fourth Annual International Conference on Transgender Law and Employment Policy, Houston, Texas, June.

1995 Cole, C. "Current Approaches in Sex Offender Treatment." Workshop presented at the Annual Conference of the Texas Corrections Association, Galveston, Texas, June.*

1995 Walling, D., Goodwin, J., and Cole, C. "Dissociation in a Transsexual Population." Paper presented at the 41st Annual Convention of The Southwestern Psychological Association, San Antonio, Texas, April.*

1995 May, E., Cole, C., and McKenzie, C. "Collaboration in the Development of Sex Offender Treatment as a Response to Sexual Abuse in Texas." Workshop presented at the Annual Training Conference of the Texas Department of Protective and Regulatory Services, Austin, Texas, May.*

1995 Cole, C. "Pharmacological Treatment of Sex Offenders - Does Chemical Castration Work?." Invited presentation to the Harris County Criminal Lawyers Association, Houston, Texas, February.

1994 Cole, C., Meyer, W., Reed, N., Kercher, G., Reyes, L., Rodgers, P., and May, E. "The Development of Sex Offender Treatment Policy for The State of Texas: A Model for Other States." Workshop presented at The Thirteenth Annual Research and Treatment Conference of The Association for the Treatment of Sexual Abusers, San Francisco, California, November.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1994 McMurrey, C., Cole, C., Emory, L., and O'Brien, J. "A Team-Based Model for the Assessment and Treatment of Adult Sex Offenders: A Treatment and Supervision Collaboration." Workshop presented at The Third Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, Huntsville, Texas, October.*

1994 Cole, C. "Sex Offender Treatment: State of the Art." Invited address presented at the Midcontinent Region Annual Conference of the Society for the Scientific Study of Sexuality (SSSS), Austin, Texas, May.

1994 Cole, C. "Sexuality Following Traumatic Brain Injury." Workshop presented at The Third Texas Instructional Institute on Traumatic Brain Injury, sponsored by The Southwest Regional Brain Injury Rehabilitation and Prevention Center, Austin, Texas, January.*

1993 Cole, C. "Sexual Counseling for Individuals with Disability" and "Homosexuality Among Individuals with Disability." Workshops presented at a conference entitled "Taboo Topics in Rehabilitation: Sexuality and Substance Abuse - Effecting Positive Outcomes", The Institute of Rehabilitation and Research (TIRR), Houston, Texas, November.*

1993 Cole, C., and Meyer, W. "Pharmacological Intervention in Conjunction with Intensive Counseling for Sexually Offending Behavior." Paper presented at the Texas Psychological Association Annual Conference, Austin, Texas, November.*

1993 Cole, C., Emory, L., O'Boyle, M., and Meyer, W. "Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses." Paper presented at the Thirteenth International Symposium on Gender Dysphoria, New York City, New York, October.*

1993 Cole, C., Emory, L., and Meyer, W. "Treatment of Sexually Offending Behaviors Following Traumatic Brain Injury." Paper presented at the Third International Congress on the Treatment of Sex Offenders, University of Minnesota, Minneapolis, Minnesota, September.*

1993 Cole, C. and May, E. "Treatment of Sex Offenders." Workshop presented at the Annual Conference of the Texas Council of Community MH-MR Centers, Lubbock, Texas, July.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1993 Emory, L., Cole, C., and Meyer, W. "Treatment of Sexual Offending Behaviors." Presentation to the Department of Psychiatry and Behavioral Sciences Grand Rounds Series, University of Texas Medical Branch, Galveston, Texas, February.

1993 Cole, C. "Sexuality After Brain Injury." Invited workshop presented to The Challenge Program, The Institute of Rehabilitation and Research (TIRR), Houston, Texas, January.

1993 Cole, C., Huang, T., and Emory, L. "Treatment of Gender Dysphoria or Transsexualism." Presentation to the Department of Psychiatry and Behavorial Sciences Grand Rounds Series, University of Texas Medical Branch, Galveston, Texas, January.

1992 Emory, L., Cole, C., and Meyer, W. "Use of Medication in the Treatment of Sex Offenders." Paper presented at the First Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, Huntsville, Texas, October.*

1992 Emory, L. and Cole, C. "Antiandrogen Therapy in Treatment of Paraphilic Disorders." Paper presented at the Annual Conference of the National Council on Sexual Addictions/Compulsivity, New Orleans, Louisiana, June.*

1992 Meyer, W., Cole, C., and Emory L. "Depo-Provera Treatment for Sex Offending Behavior: An Evaluation of Outcome." Poster presented at the 47th Annual Meeting of the Society of Biological Psychiatry, Washington, DC, May.*

1991 Emory, L., Cole, C., and Meyer, W. "The Texas Experience with Depo-Provera." Paper presented at The Second International Conference on Treatment of Sex Offenders, University of Minnesota, Minneapolis, Minnesota, September.*

1991 Emory, L., Cole, C., and Meyer, W. "Treatment of Sex Offenders." Workshop presented at The 46th Annual Texas Institute on Children and Youth, Hunt, Texas, September.

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1990 Cole, C., Emory, L., and Meyer, W. "Depo-Provera and Treatment of Sex Offenders." Workshop presented at the Second Annual Psychiatric Services Convention, Texas Department of Criminal Justice - Institutional Division, Huntsville, Texas, December.*

1990 Meyer, W., Cole, C., and Emory, L. "Depo-Provera Therapy for Sex Offending Behavior." Paper presented at the XXI Congress of the International Society of Psychoendocrinology, Niagara Falls, New York, August.*

1990 Cole, C., Levin, L., and Pichitino, J. "Psychological Interventions in Head Injury Rehabilitation." Workshop presented at the Annual Conference of the Texas Head Injury Association, San Antonio, Texas, July.*

1990 Cole, C. "Treatment of the Sex Offender." Paper presented at the Region VI Semi-Annual Training Conference, Texas Department of Criminal Justice - Pardons and Paroles Division, Galveston, Texas, June.*

1989 Cole, C. "Transsexualism: Diagnosis and Treatment of Gender Dysphoria." Workshop presented at the Texas Psychological Association Annual Conference, Houston, Texas, November.*

1989 Cole, C. and Davis, N. "Sexual Education and Treatment." Paper presented at the Annual Conference of the Texas Head Injury Foundation, Austin, Texas, August.*

1988 Quijano, W., DeLipsey, J., and Cole, C. "Treatment Issues in the Management of Sex Offenders." Symposium presented at the Texas Psychological Association Annual Conference, Austin, Texas, November.*

1988 Cole, C. and Davis, N. "Sexual Adjustment After Brain Injury." Paper presented at the Annual Conference of the Texas Head Injury Foundation, Austin, Texas, August.*

1988 Blackerby, W. and Cole, C. "Sexual Dysfunction and Adjustment Following Head Injury." Workshop presented at the Third Annual Symposium on Advances in Head Injury Rehabilitation, Dallas, Texas, March.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1987 Cole, C. and Emory, L. "Treatment of Male Sex Offenders." Half-day seminar presented in conjunction with the Central Texas Medical Foundation and HCA Shoal Creek Hospital, Austin, Texas, December.

1987 Cole, C. and Huang, T. "Transsexuality: Pathology or Alternate Path." Presentation to the Department of Psychiatry and Behavorial Sciences Academic Lecture Series, University of Texas Medical Branch, Galveston, Texas, October.

1987 Cole, C. and Emory, L. "Dealing With The Difficult Client: The Sex Offender." Workshop presented to the Texas Probation Association, Galveston, Texas, September.*

1987 Cole, C. and Emory, L. "Counseling the Sex Offender." Workshop presented at the Texas Correctional Association Annual Conference, Galveston, Texas, June.*

1987 Emory, L., Cole, C., and Amparo, E. "Anatomic Variations of the Corpus Colliseum in Persons with Gender Dysphoria." Paper presented at the Tenth International Symposium on Gender Dysphoria, Amsterdam, Netherlands, June.*

1987 Cole, C. and Emory, L. "Antiandrogenic Treatment of Sexually Offending Behaviors." Workshop presented at the Fifteenth Annual Symposium of the Houston Behavior Therapy Association (entitled "Addictive Disorders"), Houston, Texas, April.*

1986 Cole, C. "Transsexualism: A Follow-up Study." Paper presented at the Annual Meeting of the Texas Society of Psychiatric Physicians, Galveston, Texas, November.*

1986 Cole, C. and Emory, L. "Transsexualism: Current Concepts and Treatment Approaches." Workshop presented at the Annual Conference of the American Association of Sex Educators, Counselors, and Therapists (District 3), Houston, Texas, November.*

1986 Cole, C. and Emory, L. "Current Approaches in Treating the Sex Offender." Workshop presented at the Texas Correctional Association Annual Conference, College Station, Texas, October.*

PROFESSIONAL PRESENTATIONS AND ABSTRACTS continued:

1986 Cole, C. Emory, L., Copeland, D., and Strohbach, C. "Sexual Abuse: Treating the Adult and Juvenile Offender." Workshop presented to the Galveston County Human Services Forum, Galveston, Texas, January.

1985 Cole, C. "Understanding the Transsexual Phenomenon." Workshop presented at the Texas Psychological Association Annual Conference, Houston, Texas, November.*

1985 Cox, M., Cole, C., and DeLipsey, J. "Child Sexual Abuse: Strategies for Victim and Offender Evaluation and Treatment." Workshop presented at the Texas Psychological Association Annual

1985 Cole, C. "Antiandrogenic Treatment for Sexually Offending Behavior." Paper presented at the Annual Conference of the American Association of Sex Educators, Counselors, and Therapists (Districts 3 and 5), New Orleans, Louisiana, October.*

1985 Cole, C. and Emory, L. "Sex Reassignment Surgery in Texas." Paper presented at the Ninth International Symposium on Gender Dysphoria, Minneapolis, Minnesota, September.*

1985 Cole, C. and Emory, L. "Depo-Provera and the Sex Offender." Workshop presented to the Texas Association of Alcoholism and Drug Abuse Counselors, Galveston, Texas, June.*

1985 Cole, C. "Understanding Male Sexual Dysfunction." Invited address presented at the 13th Annual Physician Assistant Conference, San Antonio, Texas, May.

1985 Cole, C. and Emory, L. "Treatment Programs for Sex Offenders in Texas." Paper presented at annual conference on "Diagnosis and Treatment of Sex Offenders", Johns Hopkins Medical Institutions, Baltimore, Maryland, February.*

1983 Cole, C. "Child Abuse." Workshop presented to staff and parents of Galveston County Head Start Program, Galveston, Texas, February.

ADDITIONAL CONTINUING EDUCATION PROGRAMS ATTENDED continued:
(CE units awarded)

2011	Nineteenth Annual Conference on the Management of Adults and Juveniles with Sexual Behavior Problems, sponsored by the Council on Sex Offender Treatment, Austin, Texas, February.
2010	Eighteenth Annual Conference on The Management of Adults and Juveniles with Sexual Behavior Problems, sponsored by the Council on Sex Offender Treatment, San Antonio, Texas, February.
2009	Seventeenth Annual Conference on The Management of Adults and Juveniles with Sexual Behavior Problems, sponsored by The Council on Sex Offender Treatment, Austin, Texas, March.
2008	Deciding a Child's Fate: Child Custody Evaluations, Ethics, and Investigating Allegations of Sexual Abuse, sponsored by the Galveston County Justice Center, Galveston, Texas, March.
2008	Sixteenth Annual Conference on the Management of Adults and Juveniles with Sexual Behavior Problems, sponsored by The Council on Sex Offender Treatment, Galveston, Texas, February.
2007	Fifteenth Annual Conference on The Management of Adults and Juveniles with Sexual Behavior Problems, sponsored by The Council on Sex Offender Treatment, Austin, Texas, February.
2006	Annual Meeting of the Society for the Scientific Study of Sexuality, sponsored by the SSSS, Las Vegas, Nevada, November.
2006	Fourteenth Annual Texas Conference on Juveniles with Sexual Behavior Problems, sponsored by the Council on Sex Offender Treatment, San Antonio, Texas, July.
2006	Fourteenth Annual Texas Conference on The Management of the Adult Sex Offender, sponsored by the Council on Sex Offender Treatment, San Antonio, Texas, March.
2005	Thirteenth Annual Texas Conference on Juveniles with Sexual Behavior Problems, sponsored by the Council on Sex Offender Treatment, Austin, Texas, July.
2005	Thirteenth Annual Texas Conference on The Management of the Adult Sex Offender, sponsored by the Council on Sex Offender Treatment, Austin, Texas, February.

ADDITIONAL CONTINUING EDUCATION PROGRAMS ATTENDED continued:
(CE units awarded)

2004	Twelfth Annual Texas Conference on Juveniles with Sexual Behavior Problems, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, San Antonio, Texas, July.
2004	Twelfth Annual Texas Conference on the Management of the Adult Sex Offender, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Galveston, Texas, March.
2003	Eleventh Annual Conference on the Treatment and Supervision of Juvenile Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Austin, Texas, July.
2003	Eleventh Annual Conference on the Treatment and Supervision of Adult Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Dallas, Texas, February.
2002	"Living Safely: Reintegration of Juveniles into the Community." Tenth Annual Conference on the Treatment and Supervision of Juvenile Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, San Antonio, Texas, July.
2002	Tenth Annual Conference on the Treatment and Supervision of Adult Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Corpus Christi, Texas, February.
2001	Seventeenth International Symposium on Gender Dysphoria (HBIGDA), Galveston, Texas, USA, November.
2001	"Partnership in Treatment and Supervision." Ninth Annual Conference on the Treatment and Supervision of Juvenile Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Austin, Texas, July.
2001	Ninth Annual Conference on the Treatment and Supervision of Adult Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Houston, Texas, February.
2000	"The Key: Different Perspectives on Treatment." Eighth Annual Conference on the Treatment and Supervision of Juvenile Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Austin, Texas, July.

ADDITIONAL CONTINUING EDUCATION PROGRAMS ATTENDED continued:
(CE units awarded)

2000	Eighth Annual Conference on The Treatment and Supervision of Adult Sex Offenders, sponsored by the Correctional Management Institute of Texas, Sam Houston State University, Addison, Texas, February.
2000	"Effective Supervision of Adult Sex Offenders in the Community." National Institute of Corrections and Galveston College Criminal Justice Programs, Galveston, Texas, February.
1999	Brain Injury Association of Texas 1999 Annual Conference, Houston, Texas, August.
1999	"Where We Are and Where We Should Be." Seventh Annual Conference on the Treatment and Supervision of Juvenile Sex Offenders, sponsored by The Council on Sex Offender Treatment, The Texas Probation Training Academy, The Texas Juvenile Probation Commission, and The Texas Youth Commission, Austin, Texas, July.
1998	Seventeenth Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers (ATSA), Vancouver, British Columbia, Canada, October.
1998	"Toward the 21st Century." Seventh Annual Texas Conference on the Treatment and Supervision of Adult Sex Offenders, sponsored by The Council on Sex Offender Treatment and Sam Houston State University, San Antonio, Texas, October.
1998	"Working with the Juvenile Sex Offender." Sixth Annual Conference sponsored by The Council on Sex Offender Treatment, The Texas Probation Training Academy, The Texas Juvenile Probation Commission, and The Texas Youth Commission, Austin, Texas, July.
1997	Fifteenth International Symposium on Gender Dysphoria, (HBIGDA), Vancouver, British Columbia, Canada, September.
1997	Sixth Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, November.
1997	"Working with the Juvenile Sex Offender." Fifth Annual Conference sponsored by The Council on Sex Offender Treatment, The Texas Probation Training Academy, The Texas Juvenile Probation Commission, and The Texas Youth Commission, Austin, Texas, July.

1996 Fifth Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, October.

1996 "Working with the Juvenile Sex Offender." Fourth Annual Conference sponsored by The Council on Sex Offender Treatment, The Texas Youth Commission, and The Texas Juvenile Probation Commission, Austin, Texas, July.

1995 Sixth Annual Texas Forensic Mental Health Conference, Vernon State Hospital, Vernon, Texas, April.

1995 Fourteenth Annual Research and Treatment Conference of The Association for The Treatment of Sexual Abusers (ATSA), New Orleans, Louisiana, October.

1995 Fourth Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, October.

1995 "Working with the Juvenile Sex Offender." Third Annual Conference sponsored by The Council on Sex Offender Treatment, The Texas Youth Commission, and The Texas Juvenile Probation Commission, Austin, Texas, July.

1995 "DSM IV: Method or Madness, An Overview and Discussion of the Changes in the DSM." Institute for Living, Mainland Center Hospital, Texas City, Texas, May.

1994 Thirteenth Annual Research and Treatment Conference of The Association for The Treatment of Sexual Abusers (ATSA), San Francisco, California, November.

1994 Third Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, October.

1994 "Working with the Juvenile Sex Offender." Second Annual Conference sponsored by The Council on Sex Offender Treatment, The Texas Youth Commission, and The Texas Juvenile Probation Commission, Austin, Texas, July.

1993 Taboo Topics in Rehabilitation: Sexuality and Substance Abuse - Effecting Positive Outcomes, The Institute of Rehabilitation and Research (TIRR), Houston, Texas, November.

1993	Thirteenth International Symposium on Gender Dysphoria, (HBIGDA), New York City, New York, October.
1993	Second Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, October.
1993	Third International Congress on The Treatment of Sex Offenders, University of Minnesota, Minneapolis, Minnesota, September.
1993	"Working with the Juvenile Sex Offender." First Annual Conference sponsored by The Texas Juvenile Probation Commission and The Interagency Council on Sex Offender Treatment, Austin, Texas, July.
1992	First Annual Texas Conference on The Treatment and Supervision of Adult Sex Offenders, Sam Houston State University, Criminal Justice Institute, Huntsville, Texas, October.
1992	"Sexual Addiction/Compulsivity and Trauma: The Interrelationship." Annual Conference of the National Council on Sexual Addiction/Compulsivity, River Oaks Hospital, New Orleans, Louisiana, June.
1991	Second International Conference on The Treatment of Sex Offenders, University of Minnesota, Minneapolis, Minnesota, September.
1990	"Expanding Horizons." Annual Conference of the Texas Head Injury Association, San Antonio, Texas, July.
1990	Fifth Annual Conference on Correctional Health Care, The University of Texas Medical Branch, Galveston, Texas, June.
1989	Eleventh International Symposium on Gender Dysphoria, (HBIGDA), Cleveland, Ohio, September.
1989	"Making Changes." Annual Conference of the Texas Head Injury Foundation, Austin, Texas, August.
1989	Fourth Annual Symposium on Advances in Head Injury Rehabilitation, Dallas Rehabilitation Institute, Dallas, Texas, March.
1988	"Moving Ahead." Annual Conference of the Texas Head Injury Foundation, Austin, Texas, August.

ADDITIONAL CONTINUING EDUCATION PROGRAMS ATTENDED continued:
(CE units awarded)

1988 Third Annual Symposium on Advances in Head Injury Rehabilitation, Dallas Rehabilitation Institute, Dallas, Texas, March.

1988 "Sex Offenders: Focus on Treatment." Johns Hopkins Medical Institutions, Baltimore, Maryland, February.

1987 "Awareness." Annual Conference of The Texas Head Injury Foundation, Houston, Texas, August.

1987 Tenth International Symposium on Gender Dysphoria, (HBIGDA), Amsterdam, Netherlands, June.

1987 "Sex Offender: Criminals or Patients?" Johns Hopkins Medical Institutions, Baltimore, Maryland, February.

1986 "Reaching." Annual Conference of the Texas Head Injury Foundation, Amarillo, Texas, August.

1986 "What Will We Do With the Sex Offender: Medical and Legal Issues." Johns Hopkins Medical Institutions, Baltimore, Maryland, February.

1985 Ninth International Symposium on Gender Dysphoria, (HBIGDA), Minneapolis, Minnesota, September.

1985 "Diagnosis and Treatment of Sex Offenders." Johns Hopkins Medical Institutions, Baltimore, Maryland, February.

1984 "The Violent Patient." Twenty-fourth Annual Meeting of the Titus Harris Society, Houston, Texas, March.

1984 "Medical Assessment and Treatment of Sex Offenders." Johns Hopkins Medical Institutions, Baltimore, Maryland, February.

1983 "Treatment of the Sex Offender: Fact or Fiction." Rush-Presbyterian - St. Luke's Medical Center, Chicago, Illinois, September.

1981 Seventh International Symposium on Gender Dysphoria, (HBIGDA), Lake Tahoe, Nevada, March.

EXHIBIT F

STATE OF TEXAS §
DALLAS COUNTY §

AFFIDAVIT OF JAMES ALLAN SCOTT

Before me, the undersigned notary, on this day personally appeared James Allan Scott, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

"My name is James Allan Scott. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

"I was born April 5, 1954 in Davenport, Iowa. Two sisters were born before me, the middle one having severe medical issues and dying four months after birth. My parents were advised to not have any more children. Three years after my sister's death I was born, weighing 4 pounds 13 oz. which is considered premature, even by today's standards. The doctors called me a "blue baby" because I would suddenly stop breathing for unknown reasons, and I presented with an irregular heartbeat. Other conditions include poor eyesight, with color blindness and an abnormally curved eyeball with rods and cones that are defective. By the time I was eleven I was diagnosed with kypho-scoliosis. When I graduated high school at age 18, I was 4'11" inches and about 80 pounds; by age 25 I was 5'2" and nearly 120 pounds. [I now stand 4'11 ¾"]. I have never had any surgery or medical procedures outside of chiropractic for the treatment of my back but my back is deteriorating to the point where I am on daily pain medication and will be needing a wheelchair soon.

"As a little kid I never identified as a girl, or as a female. I romped and played with the neighborhood boys and although I was small I held my own, usually winning, in all the physical fights I got into. I distinctly remember telling a friend when I was four that I was going to grow up to be a man. I hated wearing girls' clothing, preferring boys shirts, jeans and shoes, and even suits and ties. That was always a fight with my mother because I wasn't a little girl. I played football, basketball, and baseball with the neighborhood boys. My first crush was not on my kindergarten teacher but on Whitney Blake, often daydreaming about kissing her and wanting to marry her. When the girls in the neighborhood wanted to play house I was always chosen to be the husband or dad, which suited me just fine. When I was in first grade I had a crush on a sixth grade girl that would let me walk her home every day carrying her books.

"As I got older the issue over clothing got bigger because of the school dress code. I did not want to wear dresses but wasn't allowed to wear pants. After school, it was a rush home to change into jeans or jeans shorts and oxford shirts. My dad bought me a tie and a blazer when I was ten and I wore those as much as my mother would allow, and then she finally gave in and I had a blazer all through high school.

"I also had girlfriends all through junior high and high school. None identified as lesbian. My first sexual experience was when I was 11 when a girl several years older than me asked me to make love to her as a guy would. During this experience she told me several times

that I looked like a guy, which stoked my ego considerably. I was forced into dating a guy when I was 14 but we were more friends than boyfriend/girlfriend.

"As I grew older I became aware of the changes in my body, and was not happy about it, feeling very alienated, but dissociating from my body. I knew I was male, but I definitely had the wrong body. I was supposed to have a penis and not breasts but had no clue how to reverse that condition which began to make me angry. Dressed I had no problem identifying as and feeling as a male. When I started my period, which was an extremely painful time of month, I knew this wasn't right and wanted some way of it stopping.

"At some point I discovered Christine Jorgensen's book in my parent's bedroom and realized that becoming a man was an entire possibility but knew that was something that most likely would not happen for me until I became an adult out on my own. I first mentioned this possibility [have a sex change] to a psychiatrist when I was 14, but he just scoffed it off and said that I was probably just a lesbian. That did not feel right to me, though, because I knew how I felt sexually about women wasn't as a woman. I wanted to be a husband and a father. In the 1970's I again mentioned how I felt to a psychologist and she told me that if I was really serious she knew someone I could discuss this with. The discussion never happened, however, because of issues I had with my mother at the time. I knew, though, that at some point I was going to have to transition or die; I was slowly dying inside as it was. Every woman that I dated as an adult knew I felt I was a man; this was not something I felt I could continue to hide.

"I met Rebecca in October 1988 and our first real date was December 19, 1988. On our first date I told her I felt like a man trapped in a woman's body. She accepted that with no problem. On October 29, 1989 we had a Holy Union in a Metropolitan Community Church. I wore a powder blue tuxedo and she wore a wedding dress. Over the course of the next several years we often discussed me having a sex change and she said that she would help me do it. The night before she broke up with me in 1995, we were looking at a catalog of clothing and there was a suit we both liked that she said she would buy me. We also again discussed transition and told me that now both my parents were dead I should start transition. That sounded good to me.

"We broke up in August of 1995 when Rebecca became involved with a male-to-female transsexual friend of hers. In September 1996, I moved to Dallas, leaving Rebecca in Florida with her new girlfriend. Around October, I began to see Dr. Jaime Vasquez at his clinic, and discussed my intense feelings of being a man. He okayed me to start seeing a gender therapist, and I began therapy with Janet Graham shortly after that. I continued therapy for a year and a half, and Dr. Vasquez continued as the physician who oversaw my transition. On April 4th, 1997, I received my first shot of testosterone. Around December 1997, I saw Dr. Lawrence Barzune to consult about having top surgery. He requested that I finish my first year of cross-dressing [not hard since I had been doing that for a long time] and have a legal name and gender change before he would consent to doing surgery, following what was known at the time as the Harry Benjamin Standards of Care. [In 1992 I had a medically necessary oophorectomy and hysterectomy due to severe endometriosis.]

"In February 1998 Rebecca broke up with her girlfriend and we reunited during a visit she made to Dallas to see me. She went with me to consult with an attorney, Lynn Carroll, about having my name and gender legally changed, and during her visit we went to the Dallas VA

Hospital to see about a job transfer, which she was able to get, with the job beginning around the first week in April.

"On March 13th, 1998 I was granted my legal name and gender change, and shortly afterward Rebecca drove from Florida to Dallas to pick me up to help her move in with me. I began changing all of my legal documents to reflect my name and gender status over the next few months after my legal change. In June I had top surgery performed at Medical City by Dr. Barzune. I decided not to consider a phalloplasty, and instead just stayed on the path to a metoidioplasty later. Plus, Rebecca and I had a satisfying sex life up to that point.

"After my discharge from the top surgery, Rebecca and I began looking for a house to buy in Cedar Hill where I had moved in 1997. In the meantime we joined Bethany Presbyterian Church in Dallas.

"At some point during this time, Rebecca suggested we get married, and on December 16th, 1998 we applied for a marriage license. On December 20th we were married at Bethany Presbyterian Church during our Christmas church service and among our church family.

"From early 1998 until September 2010 only Dr. Vasquez's office personnel and Rebecca knew of my former life as a female, except for a few close friends and a former therapist in Florida. Rebecca's co-workers at the VA Hospital and all of our friends have only known me as her husband, Jason. In the last year I have told only a few people of my former life. Even though she retained her maiden name we were known as husband and wife and introduced as such. She has recently introduced me as her "ex-husband"."

James A Scott

James Allan Scott, Affiant

Sworn to and subscribed before me by James Allan Scott on October 4, 2011.

Notary Public in and for
the State of Texas

MATTHEW ROBERT DAVIS
Notary Public, State of Texas
My Commission Expires
June 30, 2015

EXHIBIT G

February 09, 1998

To Whom It May Concern,

Re: Completion of Transexual Correction Procedures

This letter is to verify that Mr. Jason Lowry (aka Susan Annie Lowry)- DOB 04-05-54, SS #481-72-6341, is currently under our treatment at the Vasquez Family Medicine Center for the neuroendocrinological condition commonly referred to as transexualism.

When born, Mr. Lowry was assigned incorrectly by his genitals to be of the female sex, whereas it is now obvious that, throughout his childhood and adulthood, his brain was and remains of the male sex. Now acknowledging the maleness of his brain, he has been, under the guidance of this office (or reviewed by this office), correcting his outward and visible gender identification in order to correct the mistaken birth assignment and to end his internal confusion and to fit within society more comfortably. The purpose of any social corrections or of any long-term, irreversible hormonal corrections or of any cosmetic surgical corrections that he has or has not undergone were to bring - his social gender identification in line, as a man, with his brain sex of male and with his own vision of himself as being male. Thus he is a male to male (commonly referred to as a female to male) transexual.

A "real life" test, or period of cross-living, or correction of gender identity from living full-time in the female gender identity as a woman to living full-time in the male gender identity as a man, which does include long-term irreversible hormonal alteration and which may include genital cosmetic options, is required as a prerequisite to determine if the birth assignment was indeed mistaken. In my medical opinion, Mr. Jason Lowry has completed his "real life" test successfully, is a completed transexual male and has shown birth assignment to be a mistake.

Therefore, in my medical opinion and through the completion of his alterations, the original birth certificate listing Mr. Jason Lowry as a female has been revealed to be a non-negligent misstatement and should be corrected to read male.

Please feel free to contact us for any additional comment.

Sincerely,

Jaime J. Vasquez, D.O.
JJV: ro

State of Texas
County of Dallas

This Instrument was acknowledged before me
on February 9, 1998
by Ray Ortiz

JOYCE ANN PERRY
NOTARY PUBLIC
STATE OF TEXAS
Comm. Exp. 05-15-2001

Joyce Ann Perry
Signature of Officer

My Commission Expires: 05-15-2001

Joyce A. Perry, Notary Public

VASQUEZ
FAMILY MEDICINE CENTER

April 16, 1998

Iowa Department of Public Health
Bureau of Vital Records
Lucas State Office Bldg., 1st Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075

Attn: Certificates of Record

This is notification of sex change from female to male on my patient, Susan Annie Lowry, to James Allan Scott. I have also attached a copy of the degree from the 134th Judicial District Court.

If you have any questions, please contact my office.

Thank you,

Jaime J. Vasquez, D.O.
JJV/jap

JAIME J. VASQUEZ, D.O. • 2929 WELBORN ST. • DALLAS, TX 75219 • (214) 528-1083 • FAX (214) 528-3252

May 5, 2005

Re: Gender Change/Reassignment Surgery

ATTN: National Passport Information Center

This is to notify you that James Allen Scott, aka, Susan Annie Lowry, (dob 04-05-54), is an established patient in my office. This patient has been under my care since 10-08-96.

This letter is also to confirm that my patient has been granted a legal sex change from female to male. This was executed in Dallas, Texas, 134th Judicial District Court on 03-13-98. The patient's medical file includes documentation that has been notarized and signed by the Presiding Judge, Bill Sheeham, and Deputy, Marcia L. Mclain.

If you need additional information, please do not hesitate in contacting my office number. Thank you for your cooperation in this matter.

Sincerely,

Dr. Jaime J. Vasquez
JJV/jap

EXHIBIT H

261 D 388

NO. DV98-01711

IN RE	§	IN THE DISTRICT COURT
	§	
SUSAN ANNIE LOWRY,	§	134TH JUDICIAL DISTRICT
	§	
AN ADULT	§	DALLAS COUNTY, TEXAS

DECREE GRANTING NAME AND GENDER CHANGE OF ADULT

On March 13, 1998, hearing was held on the Petition for Name and Gender Change of Adult filed by SUSAN ANNIE LOWRY, Petitioner.

Petitioner appeared in person and by attorney and announced ready.

The making of a record of testimony was waived.

The Court finds:

1. Petitioner is an adult.

2. Petitioner's full true name is SUSAN ANNIE LOWRY

3. Petitioner's sex is Female.

4. Petitioner's race is Caucasian.

5. Petitioner was born on, April 5, 1954, in Davenport, Iowa.

6. Petitioner's Social Security number is 481-72-6341.

7. Petitioner's driver's license number of any licénse issued within the Past ten years is 17872451.

8. Petitioner has no FBI number or SID number.

9. No offense has been charged against Petitioner above the grade of class C misdemeanor.

10. Petitioner has not been finally convicted of a felony.

11. Petitioner's change of name and gender is in the interest or to the benefit of Petitioner and is in the interest of the public.

IT IS THEREFORE ORDERED that Petitioner's name is changed from SUSAN ANNIE LOWRY to JAMES ALLAN SCOTT and her gender is changed to "Male".

SIGNED on March 13, 1998.

Bill Sheehan

JUDGE PRESIDING

SENIOR DISTRICT JUDGE,
69th JUDICIAL DISTRICT
SITTING FOR THE JUDGE OF
THE 134th DISTRICT COURT

EXHIBIT I

2009 Iowa Code
Title 4 - Public Health
Subtitle 2 - Health-Related Activities
CHAPTER 144 - VITAL STATISTICS
144.23 - STATE REGISTRAR TO ISSUE NEW CERTIFICATE.

144.23 STATE REGISTRAR TO ISSUE NEW CERTIFICATE.

The state registrar shall establish a new certificate of birth for a person born in this state, when the state registrar receives the following:

1. An adoption report as provided in section 144.19, or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth.

2. A request that a new certificate be established and evidence proving that the person for whom the new certificate is requested has been legitimated, or that a court of competent jurisdiction has determined the paternity of the person.

3. A notarized affidavit by a licensed physician and surgeon or osteopathic physician and surgeon stating that by reason of surgery or other treatment by the licensee, the sex designation of the person has been changed. The state registrar may make a further investigation or require further information necessary to determine whether a sex change has occurred.

Section History: Early Form

[C24, 27, 31, 35, 39, § **2406**; C46, 50, 54, 58, 62, 66, § 144.21, 144.44; C71, 73, 75, 77, 79, 81, § 144.23]

Section History: Recent Form

2002 Acts, ch 1040, §1, 5; 2005 Acts, ch 89, §12

Referred to in § 600.13

EXHIBIT J

STATE OF IOWA

CERTIFICATION OF VITAL RECORD

STATE OF IOWA

IOWA STATE DEPARTMENT OF HEALTH
Division of Vital Statistics

CERTIFICATE OF LIVE BIRTH
STATE OF IOWA

Birth No. 114 — 54-18579

1 PLACE OF BIRTH a. COUNTY: Scott	2 USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE: Iowa b. COUNTY: Scott
b. CITY, TOWN, OR LOCATION: Davenport	c. CITY, TOWN, OR LOCATION: Bettendorf
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St Luke's Hospital	d. STREET ADDRESS: 1231 16th St.
d. IS PLACE OF BIRTH INSIDE CITY LIMITS? YES ☒ NO ☐	e. IS RESIDENCE INSIDE CITY LIMITS? YES ☒ NO ☐ — f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

CHILD

3. NAME (Type or print): First: James	Middle: Allan	Last: Scott		
4. SEX: Male	5a. THIS BIRTH: SINGLE ☒ TWIN ☐ TRIPLET ☐	5b. IF TWIN OR TRIPLET, WAS CHILD BORN: 1st 2D 3D	6. DATE OF BIRTH: Month April Day 5 Year 1954 Hour 8:27P M	

FATHER

7. NAME: First: James	Middle: Henry	Last: Lowry	8. COLOR OR RACE: White	
9. AGE (At time of this birth): 41 YEARS	10. BIRTHPLACE (State or foreign country): Benfield, Tenn.	11a. USUAL OCCUPATION: Chemist	11b. KIND OF BUSINESS OR INDUSTRY: Alcoa	

MOTHER

12. MAIDEN NAME: First: Mary	Middle: George	Last: Robbins	13. COLOR OR RACE: White	
14. AGE (At time of this birth): 29 YEARS	15. BIRTHPLACE (State or foreign country): Chilhowee, Tenn.	16. PREVIOUS DELIVERIES TO MOTHER (Do NOT include this birth) a. How many OTHER children are now living?	b. How many OTHER children were born alive but are now dead?	c. How many fetal deaths (fetuses born dead at ANY time after conception)?

17a. INFORMANT: Mother

17b. MOTHER'S MAILING ADDRESS: Mother

I hereby certify that this child was born alive on the date stated above.

18a. SIGNATURE: /s/ Lawrence A. Block

18b. ATTENDANT AT BIRTH: M.D. ☒ D.O. ☐ MIDWIFE ☐ OTHER (Specify)

18c. ADDRESS: Davenport, Iowa

18d. DATE SIGNED: 4-7-54

19. DATE RECD BY REG	20. REGISTRAR — File No.	21. DATE ON WHICH GIVEN NAME ADDED
April 15, 1954	/s/ Louis S. Nielsen	BY (Registrar)

This is to certify that this is a true and correct reproduction of the original record as recorded in this office, issued under authority of Chapter 144, Code of Iowa.
This copy not valid unless prepared on engraved border displaying state seal and signature of the Registrar.

OCT 21 2010
DATE ISSUED

S1303393

FORM #588-0328S (03/2010)

Chester J. Culver
GOVERNOR, STATE OF IOWA
Patty Judge, Lt. Governor

Jill L. Lorance
DEPUTY STATE REGISTRAR

WARNING: IT IS ILLEGAL TO DUPLICATE THIS COPY

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT K

No. 3318

STATE OF TEXAS

MARRIAGE LICENSE

COUNTY OF DALLAS

To all licensed or ordained Christian Ministers and Priests, Jewish Rabbis, or persons who are officers of religious organizations, and who are duly authorized by the organization to conduct marriage ceremonies, Justices of the supreme court, Judges of the court of criminal appeals, Justices of the courts of civil appeals, Judges of the district, county, and probate courts, Judges of the county courts at law, courts of domestic relations and juvenile courts, Justices of the peace, and Judges of the Federal courts of this State.

GREETING:

YOU ARE HEREBY AUTHORIZED TO CELEBRATE THE

RITES OF MATRIMONY

Between JAMES ALLAN SCOTT

and REBECCA L ROBERTSON *and*

make due return to the Clerk of the County Court of said County within thirty days thereafter, certifying your action under this License.

Witness *my official signature and seal of office at office in Dallas, Texas this* 16 *day of* DEC *A.D. 19*98

At 12:25 *AM/PM*

Earl Bullock, County Clerk

By Yolanda Wilson *Deputy.*
YOLANDA WILSON

I, the undersigned hereby certify that on the 20 *day of* December *19* 98

I united in Marriage the parties above named.

Witness *my hand,*

Rev. Todd B. Freeman — Rev. Todd B. Freeman
TYPE OR PRINT OFFICIAL'S NAME — OFFICIAL SIGNATURE

Pastor 4523 Cedar Springs, Dallas, 75219
OFFICIAL TITLE AND CORRECT ADDRESS

County of Marriage Dallas

Witnesses: *Permissible, but not required.*

WITNESS

WITNESS

JAN 04 1999
Recorded

99001 00301

By my signature I affirm that I have distributed to each applicant the printed materials relating to AIDS and HIV infection prepared by the Texas Department of Health as required by Section 3, Chapter 1195, Subsection (e), Sec. 1.07, Acts of the 71st Legislature, Regular Session, 1989.

In Accordance with SECTION 1. Subsection (a), Section 1.81, Family Code, effective April 11, 1985. This marriage license will expire at the end of the 30th day following the date of issuance.

Distributed and issued this 16 day of DEC A.D. 19 98 .

By Yolanda Wilson Deputy
YOLANDA WILSON

Earl Bullock, County Clerk
Dallas County, Texas

Returned and filed for record JAN 04 1999 A.D. 19
and recorded the JAN 04 1999 A.D. 19
By Lavona Swinney DEPUTY Earl Bullock, County Clerk

FORM 499

DATE OF BIRTH OF MALE 04-05-54 PLACE OF BIRTH OF MALE DAVENPORT IOWA

DATE OF BIRTH OF FEMALE 02-26-57 PLACE OF BIRTH OF FEMALE GAINESVILLE FL

Return Address

MR & MRS JAMES ALLAN SCOTT
434 WHITLEY ST
CEDAR HILL TX 75104

99001 00302

EXHIBIT L

STATE OF TEXAS §
Tarrant COUNTY §

AFFIDAVIT OF JEAN C. MARTIN

Before me, the undersigned notary, on this day personally appeared Jean C. Martin, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

1. "My name is Jean C. Martin. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

2. "I am an enrolled agent qualified to practice before the Internal Revenue Service. I am employed as a tax preparer by the Law Office of Jerry B. Jackson, P.C., located at 1800 N. Norwood, Suite 104, Hurst, Texas, 76054-3098.

3. "Since 2003, I have prepared federal tax returns for Rebecca Robertson and Jason Scott. Ms. Robertson and Mr. Scott have held themselves out to me to be a married couple throughout the time I have prepared their tax returns.

4. "Beginning in tax year 2003, Ms. Robertson and Mr. Scott signed authorizations enabling the e-filing of their tax returns. I personally e-filed the tax returns for Ms. Robertson and Mr. Scott for each tax year from 2003 through 2010. I prepared and filed these tax returns at or near the time that the information and documentation was provided me directly by Ms. Robertson and Mr. Scott.

5. "I also have maintained accurate records of these tax filings, and am the custodian of these records. It is regular practice in my business to maintain such records, and I did so in the regular course of business.

6. "I can personally attest that, for each tax year beginning 2003 and ending 2010, Ms. Robertson and Mr. Scott filed their return as 'Married-Filing Jointly.'"

Jean C. Martin
Jean C. Martin

Sworn to and subscribed before me by Jean C. Martin on October 3, 2011.

Teri C. Hyman
Commission Expires
09-08-15

Teri C. Hyman
Notary Public in and for the State of Texas

EXHIBIT M

1040 U.S. Individual Income Tax Return 2004

(99) IRS Use Only - Do not write or staple in this space.

OMB No. 1545-0074

For the year Jan. 1-Dec. 31, 2004, or other tax year beginning , 2004, ending 20

Your first name and initial: JAMES A	Last name: SCOTT	Your social security number: [redacted] 6341
If a joint return, spouse's first name and initial: REBECCA L	Last name: ROBERTSON	Spouse's social security number: [redacted] 7840
Home address (number and street). If you have a P.O. box, see page 16.: 824 PASSIVE DR	Apt. no.	▲ Important! ▲ You must enter your SSN(s) above.
City, town or post office, state, and ZIP code. If you have a foreign address, see page 16.: CEDAR HILL, TX 75104		

Label (See instructions on page 16.) Use the IRS label. Otherwise, please print or type.

Presidential Election Campaign (See page 16.) ▶ **Note.** Checking "Yes" will not change your tax or reduce your refund. Do you, or your spouse if filing a joint return, want $3 to go to this fund? ▶ You: Yes X No Spouse: Yes X No

Filing Status

Check only one box.

1 Single
2 X Married filing jointly (even if only one had income)
3 Married filing separately. Enter spouse's SSN above and full name here. ▶
4 Head of household (with qualifying person). (See page 17.) If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 Qualifying widow(er) with dependent child (see page 17)

Exemptions

6a X Yourself. If someone can claim you as a dependent, do not check box 6a
b X Spouse

Boxes checked on 6a and 6b: 2

c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if qualifying child for child tax credit (see page 18)

No. of children on 6c who:
- lived with you
- did not live with you due to divorce or separation (see page 18)

Dependents on 6c not entered above

Add numbers on lines above ▶ 2

If more than four dependents, see page 18.

d Total number of exemptions claimed

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see page 19.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	82312.
8a	Taxable interest. Attach Schedule B if required		8a	1485.
b	Tax-exempt interest. Do not include on line 8a	8b 994.		
9a	Ordinary dividends. Attach Schedule B if required		9a	24.
b	Qualified dividends (see page 20)	9b		
10	Taxable refunds, credits, or offsets of state and local income taxes		10	
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶		13	2467.
14	Other gains or (losses). Attach Form 4797		14	
15a	IRA distributions 15a	b Taxable amount (see page 22)	15b	2019.
16a	Pensions and annuities 16a	b Taxable amount (see page 22)	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits 20a	b Taxable amount (see page 24)	20b	
21	Other income. List type and amount (see page 24)		21	
22	Add the amounts in the far right column for lines 7 through 21. This is your **total income** ▶		22	88307.

Adjusted Gross Income

23	Educator expenses (see page 26)		23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ		24	
25	IRA deduction (see page 26)		25	
26	Student loan interest deduction (see page 28) STMT 4		26	2500.
27	Tuition and fees deduction (see page 29) STATEMENT 1		27	711.
28	Health savings account deduction. Attach Form 8889		28	
29	Moving expenses. Attach Form 3903		29	
30	One-half of self-employment tax. Attach Schedule SE		30	
31	Self-employed health insurance deduction (see page 30)		31	
32	Self-employed SEP, SIMPLE, and qualified plans		32	
33	Penalty on early withdrawal of savings		33	
34a	Alimony paid b Recipient's SSN ▶		34a	
35	Add lines 23 through 34a		35	3211.
36	Subtract line 35 from line 22. This is your **adjusted gross income** ▶		36	85096.

1040 U.S. Individual Income Tax Return 2007

IRS Use Only - Do not write or staple in this space. OMB No. 1545-0074

For the year Jan. 1-Dec. 31, 2007, or other tax year beginning , 2007, ending , 20

Label (See instructions on page 12.) Use the IRS label. Otherwise, please print or type.

	Your first name and initial	Last name	Your social security number
	JAMES A	SCOTT	[redacted] 6341
	If a joint return, spouse's first name and initial	Last name	Spouse's social security number
	REBECCA L	ROBERTSON	[redacted] 7840
	Home address (number and street). If you have a P.O. box, see page 12.	Apt. no.	You must enter ▲ your SSN(s) above. ▲
	824 PASSIVE DR		Checking a box below will not change your tax or refund.
	City, town or post office, state, and ZIP code. If you have a foreign address, see page 12.		
	CEDAR HILL, TX 75104		

Presidential Election Campaign ▶ Check here if you, or your spouse if filing jointly, want $3 to go to this fund (see page 12) ▶ ☐ You ☐ Spouse

Filing Status Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child (see page 14)

Exemptions

6a ☒ Yourself. If someone can claim you as a dependent, do not check box 6a — Boxes checked on 6a and 6b: 2
b ☒ Spouse
c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if qualifying child for child tax credit (see page 15)

No. of children on 6c who: ● lived with you ● did not live with you due to divorce or separation (see page 16)
Dependents on 6c not entered above
Add numbers on lines above ▶ 2

If more than four dependents, see page 15.

d Total number of exemptions claimed

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see page 19.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	74977.
8a	Taxable interest. Attach Schedule B if required		8a	23.
b	Tax-exempt interest. Do not include on line 8a	8b 975.		
9a	Ordinary dividends. Attach Schedule B if required		9a	405.
b	Qualified dividends (see page 19)	9b 54.		
10	Taxable refunds, credits, or offsets of state and local income taxes		10	
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13	269.
14	Other gains or (losses). Attach Form 4797		14	
15a	IRA distributions	15a	b Taxable amount	15b
16a	Pensions and annuities	16a	b Taxable amount	16b
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits	20a	b Taxable amount (see page 24)	20b
21	Other income. List type and amount (see page 24)		21	
22	Add the amounts in the far right column for lines 7 through 21. This is your total income ▶		22	75674.

Adjusted Gross Income

23	Educator expenses (see page 26)	23		
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
25	Health savings account deduction. Attach Form 8889	25		
26	Moving expenses. Attach Form 3903	26		
27	One-half of self-employment tax. Attach Schedule SE	27		
28	Self-employed SEP, SIMPLE, and qualified plans	28		
29	Self-employed health insurance deduction (see page 26)	29		
30	Penalty on early withdrawal of savings	30		
31a	Alimony paid b Recipient's SSN ▶	31a		
32	IRA deduction (see page 27)	32		
33	Student loan interest deduction (see page 30)	33		
34	Tuition and fees deduction. Attach Form 8917	34		
35	Domestic production activities deduction. Attach Form 8903	35		
36	Add lines 23 through 31a and 32 through 35		36	
37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37	75674.

Form **1040** **U.S. Individual Income Tax Return** **2010** (99) IRS Use Only - Do not write or staple in this space.

OMB No. 1545-0074

Name, Address, and SSN

PRINT CLEARLY

For the year Jan. 1-Dec. 31, 2010, or other tax year beginning 2010, ending 20

	Last name	Your social security number
Your first name and initial: JAMES A	SCOTT	[redacted] 6341
If a joint return, spouse's first name and initial: REBECCA L	Last name: ROBERTSON	Spouse's social security number: [redacted] 7840
Home address (number and street). If you have a P.O. box, see instructions.: 824 PASSIVE DR	Apt. no.	Make sure the SSN(s) above and on line 6c are correct.
City, town or post office, state, and ZIP code: CEDAR HILL, TX 75104		Checking a box below will not change your tax or refund.

See separate instructions.

Presidential Election Campaign ▶ Check here if you, or your spouse if filing jointly, want $3 to go to this fund ▶ ☐ You ☐ Spouse

Filing Status Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☒ Yourself. If someone can claim you as a dependent, do not check box 6a — Boxes checked on 6a and 6b: 2
b ☒ Spouse
c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit

If more than four dependents, see instructions and check here ▶ ☐

No. of children on 6c who: ● lived with you ____ ● did not live with you due to divorce or separation (see instructions) ____
Dependents on 6c not entered above ____
Add numbers on lines above ▶ 2

d Total number of exemptions claimed

Income

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	81581.
8a	Taxable interest. Attach Schedule B if required		8a	
b	Tax-exempt interest. Do not include on line 8a	8b 530.		
9a	Ordinary dividends. Attach Schedule B if required		9a	291.
b	Qualified dividends	9b 87.		
10	Taxable refunds, credits, or offsets of state and local income taxes		10	
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13	
14	Other gains or (losses). Attach Form 4797		14	
15a	IRA distributions	15a / b Taxable amount	15b	
16a	Pensions and annuities	16a / b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	-30.
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits	20a / b Taxable amount	20b	
21	Other income. List type and amount		21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶		22	81842.

If you did not get a W-2, see page 20.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	One-half of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 31a and 32 through 35	36	
37	Subtract line 36 from line 22. This is your adjusted gross income ▶	37	81842.

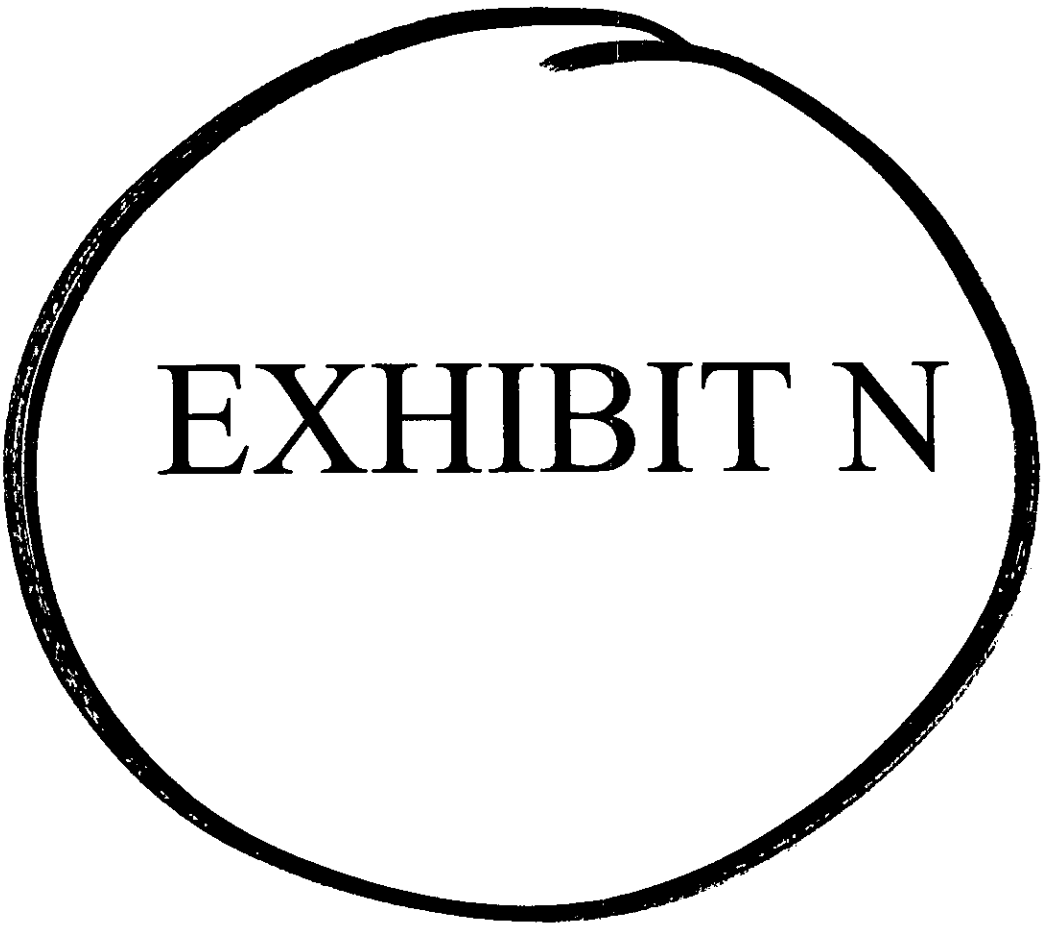
EXHIBIT N

STATE OF TEXAS §
§
DALLAS COUNTY §

AFFIDAVIT OF JAMES ALLAN SCOTT

Before me, the undersigned notary, on this day personally appeared James Allan Scott, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

1. "My name is James Allan Scott. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

2. The court order handed down by the 134th Judicial District in Dallas, County, marked as Exhibit H, is a certified copy given to me. The courtesy copy supplied to counsel is an exact photocopy, and therefore a fair and accurate representation, of the court order given to me.

3. The birth certificate, marked as Exhibit J, is a certified copy given to me by the Iowa State Department of Health. The courtesy copy supplied to counsel is an exact photocopy, and therefore a fair and accurate representation, of the birth certificate given to me.

4. The marriage license, marked as Exhibit K, is the original given to me by the County Clerk of the County of Dallas. The courtesy copy supplied to counsel is an exact photocopy, and therefore a fair and accurate representation, of the marriage license given to me.

5. The 1040 IRS forms from 2004, 2007, and 2010, marked as Exhibit M, are the exact photocopies, and therefore a fair and accurate representation, of the tax returns e-filed by our enrolled agent qualified to practice before the IRS, Jean C. Martin."

James A Scott
Signature of Affiant

Sworn to and subscribed before me by James Allan Scott on October 5, 2011.

Notary Public

MATTHEW ROBERT DAVIS
Notary Public, State of Texas
My Commission Expires
June 30, 2015