

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, et al.,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS
COUNTY, FLORIDA,

Defendant.

No. 3:17-cv-00739-TJC-JBT

**PLAINTIFF’S MOTION TO PRECLUDE DR. JOSEPHSON FROM TESTIFYING
AND
OFFERING ANY PURPORTED EXPERT OPINION IN THIS MATTER**

Plaintiff, Drew Adams (“Plaintiff”), by and through his mother Erica Adams Kasper, moves this Court for an order precluding Defendant from offering any testimony or opinions by Allan M. Josephson, M.D. (“Dr. Josephson”) – including the opinions set forth in his Report dated October 2, 2017 (“Report”)¹ and his Rebuttal Report dated November 3, 2017 (“Rebuttal Report”)² – on the bases that: (1) Dr. Josephson lacks specialized knowledge and is not a qualified expert on any issue before the Court; (2) Dr. Josephson’s opinions are not

¹ Dkt. 85-1.

² Dkt. 89; 89-1 (Defendant filed the redacted Rebuttal Report and provided a copy under seal).

based on scientific methodology but rather “untested hypothesis,” speculation, and assumptions that lack any scientific or medical support; and (3) Dr. Josephson’s testimony is not based on sufficient facts or data and his irrelevant, fringe views on transgender patients are “absolutely” “in the minority”³ and contrary to all accepted medical standards of care.⁴

As detailed below, Dr. Josephson’s proposed testimony and opinions are irrelevant to the claims and defenses in this case, they lack a reliable foundation, and fail to meet any of the standards set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 597 (1993) or Federal Rule of Evidence 702. Based on Dr. Josephson’s testimony, this Court should exercise its role as gatekeeper to bar him from inserting his baseless speculation and viewpoints, which do not constitute *expert* opinions even applying the most lenient standards.

I. BACKGROUND

A. Dr. Josephson’s Testimony Demonstrates that he is Not an Expert on Gender Dysphoria, Transgender Youth or Healthcare, or Gender Identity

Dr. Josephson admitted – as he must – that he is not an expert in treating transgender patients or in treating patients with gender dysphoria and that he has not developed any expertise in the issues that are presented in this case.⁵ And, although he implies through his statement that he is an expert “in the assessment and treatment of adolescents and experienced in the delivery of family oriented psychiatric care” (Report, ¶4) that he has information relevant to the issues here, his testimony establishes handily that the opposite is

³ Deposition of Allan M. Josephson (“Josephson Depo”), attached as Exhibit A to the concurrently filed Declaration of Natalie Nardecchia, p. 280:6-8.

⁴ In its Rule 26 Disclosure, Defendant designated Dr. Josephson as its only expert witness in this case. Dr. Josephson signed his Report on October 2, 2017, and his Rebuttal on November 3, 2017. *See* Dkt. Nos. 85-1; 89-1.

⁵ Josephson Depo., pp. 86:1-18; 88:1-13; 102:9-14.

true. In forty-one years, Dr. Josephson has never published a study analyzing transgender identity or healthcare, or gender dysphoria, has not been engaged in any peer-reviewed analyses in these areas and has not engaged in any scientific studies in this area including any research on related topics.⁶ Dr. Josephson has never given a presentation on transgender identity or gender dysphoria in any serious medical or scientific setting. *Id.*, pp. 215:23-216:1. He has never undertaken any coursework to better understand transgender healthcare issues, never been a part of any of the professional organizations that promulgate standards of care for transgender healthcare, and (unlike his colleagues at University of Louisville) he does not list LGBT healthcare as an area of interest or specialty.⁷ Dr. Josephson does not teach any courses to medical students regarding LGBT care, though his colleagues do.⁸

In his career, Dr. Josephson estimates that he has seen “approximately 60” patients who he claims identified as transgender, out of approximately 15,000 patients total. Report ¶8.⁹ However, his estimate includes *any* interaction with a transgender patient in a professional context regardless of whether any treatment or care was rendered that would relate to an issue in this case; by example, Dr. Josephson includes his “[p]ure observation” of

⁶ Josephson Depo., pp. 36:6-13; 36:7-9.

⁷ *Id.*, pp. 33:5-10; 86:11-87.3; 88:11-13; 282:20-283:4.

⁸ *Id.* at 283:5-284:1.

⁹ Dr. Josephson did not count the number of patients, and claimed to have no records from which he could ascertain the actual number. Josephson Depo., p. 216:2-9. Dr. Josephson had only purportedly seen 35 transgender patients as of August 2016 (when he began submitting expert reports for school districts), but somehow that number became 50 as of July 17, 2017. *Id.*, pp. 209:8-210:7. Given Dr. Josephson’s admitted lack of expertise in this area, the numbers strain credibility. This is why Plaintiff sought Dr. Josephson’s medical records relating to his purported treatment of such patients prior to his deposition. In light of his deposition testimony, Plaintiff believes that, at a minimum, Dr. Josephson should be required to produce these medical records if he is to be permitted to testify at trial so that Plaintiff can further confront him on his alleged treatment of transgender patients.

another physician treating her patient (without any interaction on Josephson's part whatsoever) and one-hour "very brief" interactions.¹⁰ Many of the included patients were people who Dr. Josephson treated for unrelated concerns, but who happened to be transgender, meaning that he was not treating them for issues that related to their transgender status or any diagnosis with gender dysphoria.¹¹ Dr. Josephson admitted that gender dysphoria is not his specialty and that it was "not a bad idea" to refer a transgender patient he treats to his Louisville colleagues since they actually specialize in transgender healthcare.¹²

In his Report, ¶7, Dr. Josephson states that "[w]e consult regularly with our school's division of pediatric endocrinology," and that he "review[s] transgender patients with [Dr. Brady] and others... who are providing psychiatric care to transgender youth." In his Report, he also claimed to supervise 26 clinicians who treat conditions "including gender dysphoria." *Id.* However, during deposition, Dr. Josephson admitted that *he does not work with the pediatric endocrinology division, does not review transgender patients with Dr. Brady or anyone else on staff, does not supervise anyone who treats LGBT patients, and does not supervise the treatment by any clinician of gender dysphoria.*¹³

Dr. Josephson is not recognized as an expert, or even proficient, on transgender healthcare issues by his employer. The University of Louisville's Gender Clinic, part of the endocrinology division at the medical school, is an integrated clinic focusing on gender-affirming medical care for gender dysphoric children and youth; here, transgender children

¹⁰ *Id.*, p. 101:8-17; 151:12-23.

¹¹ *Id.* at 134:9-135:13.

¹² *Id.* at 99:23-100:1.

¹³ Josephson Depo., pp. 200:20-201:23; 145:25-146:4; 191:5-192:1.

and adolescents, including those who come to the Bingham Clinic (where Dr. Josephson works)¹⁴, are seen, evaluated, and treated by Dr. Brady, a psychologist, and Dr. Kingery, a pediatric endocrinologist – professionals with expertise in treating gender dysphoric youth.¹⁵ Dr. Josephson does not work at the Gender Clinic, does not see, evaluate, or treat patients there, and has no supervisory role at the Gender Clinic.¹⁶ Dr. Josephson is not “trust[ed]” to treat transgender patients, his colleagues disagree with his views on transgender patients, and he was only permitted to visit the Gender Clinic once, accompanying Dr. Brady, and Dr. Josephson did not speak to any patient or evaluate them on that one occasion.¹⁷

B. Dr. Josephson is Not Qualified to Offer Any Opinions Regarding Drew Adams, His Identity, or His Diagnosis

Dr. Josephson testified that he has never spoken to, examined, evaluated, or treated Plaintiff; nor did he request to interview Plaintiff or conduct an IME of him.¹⁸ This, despite the fact that Dr. Josephson conceded that “speaking to a patient always clarifies things.”¹⁹ When Dr. Josephson submitted his Report, he had not reviewed any of Drew’s medical records, and, although nothing stopped him from doing so, he took no steps to speak to Drew’s treating physicians or his parents though that “might have given more information.”²⁰

¹⁴ Plaintiff learned, after Dr. Josephson’s deposition, that Dr. Josephson was forced to resign his post as CEO of the Bingham Clinic and his position as Chief of Child, Adolescent and Family Psychiatry at University of Louisville.

¹⁵ *Id.* at 204:18-25.

¹⁶ *Id.* at 101:24-102:4.

¹⁷ *Id.*, pp. 101:8-23; 114:25-115:8; 177:7-12; 185:11-186:1.

¹⁸ Josephson Depo., pp. 9:25-10:11, 19-24.

¹⁹ *Id.*, p. 10:12-18.

²⁰ *Id.*, pp. 12:1-13:4, 12-23.

Dr. Josephson admitted that he lacks knowledge regarding Drew’s medical treatment and transition, and did not know if Drew had undergone any surgeries.²¹ Dr. Josephson was unsure if Drew’s medical providers had attested that he is male.²² Dr. Josephson testified that he lacks knowledge regarding Drew’s legal transition – but agreed that if Drew has a birth certificate and driver’s license stating that he is male (which Drew does), then “that would allow him to say then that he – he is male” and “he would be male.”²³

Recognizing his knowledge of Plaintiff (“because I haven’t examined him”), Dr. Josephson testified that: he is *not offering opinions on*, or contesting, that Plaintiff is transgender, identifies as male, suffers from gender dysphoria, will continue to suffer from gender dysphoria, will continue to identify as transgender, the causes of Plaintiff’s gender dysphoria, or the propriety of Plaintiff’s medical care.²⁴ Nor is Dr. Josephson opining regarding Drew’s home life or family relationship.²⁵ Dr. Josephson also withdrew his unsound testimony that Drew should resist urinating or “hold it” in lieu of using the restroom.²⁶ Dr. Josephson has never been to Drew’s high school and is not opining on how long it takes Drew to move from his classroom to gender-neutral restrooms.²⁷

Dr. Josephson testified that the only two case-specific opinions he intends to offer are: (1) Defendant’s policy “appears to have responded to Drew’s needs”; and (2) Drew has

²¹ Josephson Depo., pp. 14:17-15:1; 16:18-19.

²² *Id.*, pp. 18:20-19:2.

²³ Josephson Depo., pp. 15:17-17:1; 36:14-37:10.

²⁴ Josephson Depo., pp. 13:24-14:1; 18:17-19, 21-23; 19:3-5; 20:16-21:8.

²⁵ *Id.*, p. 21:9-12.

²⁶ *Id.*, p. 28:11-16; *cf.* Rebuttal Report ¶75.

²⁷ *Id.*, p. 29:14-17.

not suffered “significant stress, harm, irreparable harm,” though it may be “a stress” and “difficult” and “serious.”²⁸ Dr. Josephson testified that he would “object” to the term “irreparably harmed” being “used to Drew” or “being used to a child” period.²⁹ It is his opinion that there is no harm to a child that rises to the level of “irreparable harm.” *Id.*

Dr. Josephson lacks a sufficient basis for his first opinion – as he never evaluated or spoke to Drew, and it is clear that he is not opining on *Drew’s* needs: “Well, it’s a standard policy that would respond to *any child’s need* in his situation...,” but “any child” may not have gender dysphoria or be transgender.³⁰ The “any child” in his hypothetical may not be the subject of well-documented discrimination, as Drew and other transgender students are. Dr. Josephson testified that it was “hard to conceive” of how being denied access to the boys’ restroom could be stressful for Drew, but admitted his opinion was “not based on a clinical examination” or anything particular to Drew.³¹

Dr. Josephson formed his second opinion – that Drew has suffered no harm – “[b]ased on the videos” he saw after submitting his Report.³² Instead of examining Plaintiff, talking to his doctors, or reading his medical records, Dr. Josephson watched “four or five” social media videos of Drew; the videos are Josephson’s “only database” to support his claim that Drew has suffered no harm.³³ Dr. Josephson’s knows nothing about Drew, medically or

²⁸ Josephson Depo., pp. 21:13-23; 74:4-23; 80:10-22.

²⁹ *Id.*, pp. 56:24-57:20.

³⁰ Josephson Depo., p. 24:8-15.

³¹ *Id.*, pp. 24:20-25:7.

³² Josephson Depo., pp. 21:24-22:1; 22:2-7.

³³ *Id.*, pp. 13:5-11; 22:8-12.

otherwise, other than the fact that he is a transgender teenage boy and looks like “an effeminate young boy” in the videos.³⁴

Dr. Josephson admitted there are no peer-reviewed studies or research to support his untested opinion that denying transgender students like Drew the ability to use the restroom that matches their gender identity will not harm them.³⁵ He also conceded that, “[i]f youth [are] not affirmed or not accepted as a person, [] studies show that’s not helpful.... Everyone needs to be accepted and respected – in their identity,” regarding studies showing the negative impacts on transgender youth of not being affirmed.³⁶

C. Dr. Josephson is Not Qualified to Opine Regarding Defendant’s Bathroom Policy or Privacy Rights of Other Students

Dr. Josephson testified that he is not an expert on “privacy rights,” though he intends to opine that “some kids” at Drew’s school could suffer a violation of their “privacy rights” or feel “uncomfortable” if Drew used the boys’ restroom.³⁷ Dr. Josephson lacks any factual or scientific basis for this “opinion.” First, he has no knowledge of a single person who complained or expressed any concerns, privacy or otherwise, regarding Plaintiff’s use of the boys’ restroom for the limited period before he was prohibited.³⁸ Dr. Josephson “assum[ed]” there are stalls in the sex-segregated facilities at Nease High School, and if Plaintiff used a stall in the restroom (a fact he did not know), there would be no harm to other students.³⁹

³⁴ *Id.*, pp. 78:16-20; 79:14-15.

³⁵ *Id.*, pp. 32:21-33:4; 76:10-15.

³⁶ *Id.*, pp. 37:11-19; 75:11-17.

³⁷ Josephson Depo., pp. 71:19-25; 72:10-21.

³⁸ *Id.*, pp. 39:16-40:19; 41:3-23; 42:6-43:9; 43:24-44:1, 11-23; 44:24-45:19; 72:6-9.

³⁹ *Id.*, pp. 46:15-47:1; 48:4-17; 50:6-13.

From a methodological standpoint, Dr. Josephson admitted there is no medical or scientific support for his untested theory that any student could suffer harm or a violation of their “privacy rights” if a transgender student uses the restroom or locker room.⁴⁰ He has done no research or study in this field, nor is there medical or scientific support for his untested theory.⁴¹ Dr. Josephson is not aware of any reported incident of a transgender individual assaulting or harassing a cisgender individual in a school bathroom or locker room, despite his suggestion otherwise in his Rebuttal Report.⁴² Dr. Josephson conceded that transgender students are disproportionately the *victims* of harassment, and that if a student felt uncomfortable with Drew’s presence, he could “cope” or use a gender-neutral restroom.⁴³

Based on his testimony, Dr. Josephson lacks scientific and medical knowledge to opine that the term “biological sex” is a proper basis on which to deny transgender students access to the restroom. He admitted that his opinion – that Defendant’s bathroom policy is “sound” because it separates students by their “biological sex” – is *directly contrary to the Endocrine Society Guidelines* that expressly state that the term “biological sex” is imprecise and should be avoided.⁴⁴ Dr. Josephson conceded prior to that admission that the Endocrine Society Guidelines are “one of the leading authorities on treatment of gender dysphoria,” for adults and children and that *he had not read them*.⁴⁵

⁴⁰ *Id.*, pp. 72:22-73:19.

⁴¹ *Id.* at 73:16-19; 75:18-76:15.

⁴² *Id.*, p. 70:4-13; *cf.* Rebuttal Report ¶47.

⁴³ *Id.*, pp. 52:4-1966:25-67:6; 73:20-74:3. Plaintiff agrees with these two statements (that the student who is uncomfortable could “cope” or use a gender-neutral restroom).

⁴⁴ Josephson Depo., pp. 273:6-21; 275:1-25.

⁴⁵ *Id.*, pp. 272:5-15, 20-273:1.

D. Dr. Josephson's Opinions are Methodologically Unreliable and Unsupported by Science or Medicine

Dr. Josephson repeatedly admitted to basing his opinions regarding transgender people on speculation instead of science. For instance, he opined that transitioning “could have” long-term “problems,” but admitted this was his “untested hypothesis” and pure speculation, with no scientific basis.⁴⁶ Dr. Josephson also testified that there is “only one” explanation for a higher prevalence of transgender youth versus 20 years ago – namely, “psychosocial forces”; but he again admitted there was no basis and described it as “unsettled” science.⁴⁷ Similarly, Dr. Josephson opined that some people identify as transgender because it is “culturally chic” and “cool” yet he admitted “there’s no science or data” to support this.⁴⁸

In addition to offering speculation, Dr. Josephson admitted that he lacks knowledge of current medical standards, as he only read “parts” of the Endocrine Society Guidelines and had not read the new World Professional Association for Transgender Health (“WPATH”) standards of care but testified, “I need to.”⁴⁹ Dr. Josephson agrees that he has a “different perspective” from WPATH and that he “diverts” from Endocrine Society Guidelines, which statements are odd given he has not reviewed them.⁵⁰ Dr. Josephson admitted that he is “absolutely” “in the minority” on his opinions regarding transgender patients.⁵¹

⁴⁶ Josephson Depo., pp. 236:7-237:17 (“this is not known at this time”).

⁴⁷ *Id.*, p. 63:23-8.

⁴⁸ *Id.*, pp. 304:12-16, 23-305:13.

⁴⁹ *Id.*, p. 272:5-15.

⁵⁰ *Id.*, pp. 56:6-23.

⁵¹ Josephson Depo., pp. 279:17-281:6.

The Standards of Care published by WPATH are the preeminent rules governing the treatment of transgender youth. WPATH makes clear that transgender individuals are not disordered as Dr. Josephson posits; rather, “the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available.”⁵² The American Psychological Association and American Academy of Pediatrics have constructed their own professional guidelines to complement the Standards published by WPATH.⁵³ The WPATH Standards are considered the gold standard and universally followed by every credible medical organization.⁵⁴ Dr. Josephson’s opinions are directly contrary to these standards and thus unreliable. The following are some examples.

i. Dr. Josephson’s Asserts that Transgender People are Delusional

WPATH and the DSM-5 are clear that transgender identity is not a delusion and is not indicative of psychopathology.⁵⁵ These principles contradict the central tenet of Dr. Josephson’s beliefs regarding transgender individuals, namely that gender dysphoria is a manifestation of a refusal to accept one’s own reality.⁵⁶ Parents who seek to affirm their

⁵² WPATH Standards of Care, p. 6.

⁵³ American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (“APA Guidelines”), pp. 832, 833 (2015); Levine et al., *Policy Statement: Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, *Pediatrics* 132:1 198 (2013).

⁵⁴ WPATH Standards of Care are accessible at: [https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf)

⁵⁵ DSM-5, p. 458 (“In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion”).

⁵⁶ Report, ¶¶25-26.

transgender children when they express a cross-gender identification, Josephson testifies, are neglecting their responsibilities as parents and fostering an “inaccurate” worldview.⁵⁷

Far from being a viable alternative theory of child development, Dr. Josephson’s central belief has been roundly rejected by the medical community. As noted, the DSM-5 explicitly states that transgender identity is not a delusion. According to WPATH’s Standards of Care, “[i]nexperienced clinicians may mistake indications of gender dysphoria for delusions.”⁵⁸ In fact, the American Psychological Association states that “making the assumption that psychopathology exists given a specific gender identity or gender expression,” like Dr. Josephson does, is a form of discrimination.⁵⁹

In making his unscientific assertion that gender dysphoria is a delusion, Dr. Josephson insists that gender identity is a “psychological construct”; something entirely mental in nature. Science does not support his views, however. The DSM-5 recognizes that gender identity is neither solely biological nor solely mental. Instead, “biological factors are seen as contributing, in interaction with social or psychological factors, to gender development.”⁶⁰ Once a person’s gender identity crystallizes, it is “fixed, not subject to voluntary control, cannot be voluntarily changed, and is not undermined or altered by the existence of other sex-related characteristics that do not align with it.”⁶¹

⁵⁷ Report, ¶26.

⁵⁸ WPATH Standards of Care, p. 13.

⁵⁹ APA Guidelines, p. 838. Dr. Josephson eventually withdrew his baseless opinion that being transgender means one is mentally ill during deposition. *Id.*, p. 235:9-13.

⁶⁰ DSM-5, p. 451. Dr. Josephson conceded this point. Josephson Depo., p. 259:12-16.

⁶¹ Adkins Report, p. 9.

During deposition, Dr. Josephson disavowed and contradicted some of his opinions, admitting that for some children (cisgender and transgender) their gender identity can be stable and fixed by the age of 4.⁶² Josephson also conceded that there are “the kind of real transgender [sic]” people who “are responding to something internal” and “biologic, and it persists through his development”; these children identify by 3 or 4 as being transgender.⁶³

WPATH also makes clear that an important part of treating gender dysphoria is “help[ing] families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent.”⁶⁴ Dr. Josephson’s recommended treatment, though, for parents is to deny their child’s stated gender identity.⁶⁵ Dr. Josephson has not done any research or study on the impact of his advice on this point, which contradicts standards of care.⁶⁶ Dr. Josephson incredibly testified that he would rather have a young transgender child suffer through gender dysphoria than be affirmed in their transgender identity.⁶⁷

ii. Dr. Josephson’s Advocacy for Unethical Conversion Therapy

Proper treatment for cross-gender identification, in Josephson’s mind, means to align a child’s gender identity to match his or her natal sex, or what is known as “conversion therapy”; he believes that children should be deterred from the gender identity they express and steered toward a cisgender identity, even if they have “cried and said I don’t want to” – since “kids resist things that they don’t want to do” all the time.”⁶⁸ Josephson considers the

⁶² Josephson Depo., pp. 114:25-116:1.

⁶³ *Id.*, pp. 302:7-304:11.

⁶⁴ WPATH Standards of Care, p. 15.

⁶⁵ *Id.*, pp. 117:4-9; 298:14-21.

⁶⁶ *Id.*, pp. 120:21-121:2.

⁶⁷ *Id.*, pp. 165:5-166:2.

⁶⁸ Josephson Depo., pp. 112:8-113:3; 115:9-23; 117:4-9 (“You’re not a girl. You’re a boy”).

American Academy of Pediatrics’ position that a person cannot voluntarily change their gender identity regardless of age to be “an extreme statement.”⁶⁹

Transgender people like Drew face discrimination in every level of society, including from medical professionals like Dr. Josephson, who subject them to outdated “treatments” of dubious efficacy. Perhaps the most insidious of these is “conversion” or “reparative” therapy. The APA Guidelines and WPATH Standards of Care are, on the subject of conversion or reparative therapy, unequivocal: it is unethical and ineffective.⁷⁰ It is shown to be affirmatively harmful, increasing internalized stigma, stress, and depression in transgender people, rather than alleviating the feelings that such pseudoscientific therapies supposedly “treat.”⁷¹ While Dr. Josephson carefully avoids using the phrase “conversion therapy,” he makes no secret of his belief that transgender minors are “confused” and claims that the best treatment for gender dysphoric youth is not to affirm their stated gender identity, but instead to force them to “push through” their negative feelings and “realign” their gender identity and their natal sex.⁷² The insistence on attempting to suppress or change one’s stated gender identity is conversion therapy – a “treatment” that is illegal in many states and cities.⁷³

⁶⁹ *Id.*, p. 124:10-23.

⁷⁰ APA Guidelines, p. 835; WPATH Standards of Care, p. 16.

⁷¹ *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, Policy Statement, Pediatrics Vol. 132, No. 198, 199 (2013).

⁷² See Dr. Josephson’s speech at the Heritage Foundation, accessible at:

<http://www.heritage.org/gender/event/gender-dysphoria-children-understanding-the-science-and-medicine>

⁷³ See, e.g., <https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy>

Underlying Dr. Josephson’s advocacy to align gender identity to natal sex is his other core belief that being transgender is voluntary or changeable.⁷⁴ To support this idea, he relies on and distorts research that presents two distinct eras of human development – childhood and adolescence – as monolithic. He states in his Report that between two and thirty percent of males, or twelve and fifty percent of females, who identify as transgender as children will continue to do so through the end of adolescence.⁷⁵ This is, he argues, proof that transgender identity is temporary, and should be discouraged. This statistic, however, elides two categories together. While those who identify as gender non-conforming (as opposed to being transgender) as prepubescent children may not continue to identify as such through adolescence, *transgender children* and those who first identify as transgender as adolescents are all but guaranteed to continue to do so through adulthood.⁷⁶ Often, gender dysphoria begins or intensifies when an adolescent begins to develop the secondary sex characteristics that are inconsistent with their personal gender identity.⁷⁷ Dr. Josephson’s position is predicated on what he again calls “unsettled science” (Report ¶30) and a conflation of the medical and lay definitions of what it means to be a child.⁷⁸ Meanwhile, the prevailing opinion of the medical community is that statistics regarding gender dysphoria in

⁷⁴ Josephson Depo., pp. 123:24-124:23; 221:17-24. He also believes changing sexual orientation can be done; “it’s not easy and it’s not maybe necessarily voluntary.” *Id.*, pp. 124:24-125:7.

⁷⁵ Report, ¶30.

⁷⁶ WPATH Standards of Care, p. 11.

⁷⁷ *Id.* at 12.

⁷⁸ He acknowledged this conflation in testifying that “the older” the child the “more likely to continue” and limited his opinion to pre-pubescent children; he stated teenagers are likely to persist in cross-gender identification. Josephson Depo., pp. 267:4-10; 268:15-269:10.

prepubescent children simply cannot be imputed to adolescents.⁷⁹ Attempts to do so are intellectually dishonest, and ignore the crucial developmental changes at puberty.

iii. Dr. Josephson’s Belief that Ancillary Psychological Concerns are the Cause of Gender Dysphoria

Dr. Josephson further insists that the negative psychological outcomes that are associated with adolescent gender dysphoria – namely, depression and suicidal thoughts – are not symptomatic of stigmatization and societal shame, but rather the cause of the dysphoria itself.⁸⁰ His justification is, contrary to WPATH, that stigma is too broad a concept to explain all of the negative mental and emotional pressures placed upon transgender youth.⁸¹ Instead, he believes that outside stressors cause individuals to “avoid or deny” their natal sex as a coping mechanism, and that teaching children resilience will allow them to better accept “the expectations and roles... attached to their given sex.⁸²” He points to “problematic family relationships” as one of the root causes of what he calls “the transgender position.⁸³” As evidence, he points to the high rates of depression and anxiety in transgender youth.⁸⁴

Dr. Josephson’s circular and faulty assumptions lead to flawed conclusions. The deterioration of parent-child relationships is not a cause of non-cisgender identity, though it can be an unintended result of a child’s coming out, particularly if the parents are not supportive of their transgender child.⁸⁵ Dr. Josephson ignores studies that demonstrate that

⁷⁹ Adkins Rebuttal Report, ¶11.

⁸⁰ Report, ¶29.

⁸¹ Josephson Depo., pp. 257:24-258:8.

⁸² Report, ¶35.

⁸³ *Id.*, ¶33.

⁸⁴ *Id.*, ¶29.

⁸⁵ *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, p. 964.

transgender youth with parents who support their identities do not continue to suffer from depression and anxiety at clinically elevated rates.⁸⁶ Instead, such youth do not demonstrate a psychopathological profile different from the wider population.⁸⁷ No major health organization supports Dr. Josephson's contention that transgender identity is the result of any form of psychopathology, be it a delusion or a response to some form of outside stress. For him to insist otherwise willfully ignores the consensus of the scientific community.

E. Dr. Josephson's Testimony is Inconsistent⁸⁸

In addition to the untruths described above with regard to his experience, Dr. Josephson changed his opinions on myriad issues and he testified inconsistently and evasively throughout his deposition, including but not limited to the following:

- Dr. Josephson stated in his Report that transgender people are "abnormal" but when asked if he believed gay people were also abnormal, Dr. Josephson testified that he would never use the word "'abnormal' because it's loaded with pejorative feelings." When it was pointed out that he used the word "abnormal" in referring to transgender people, Dr. Josephson contradicted himself immediately, testifying, "*oh, I don't think abnormal is pejorative at all*" and that he would "strike that" inconsistent testimony;⁸⁹
- Dr. Josephson testified in his Report and during deposition that all transgender people are "delusional" – but when pressed (and confronted with contrary WPATH guidance), Dr. Josephson changed and testified that he would not use the word

⁸⁶ Olson, *Mental Health of Transgender Children Who Are Supported in Their Identities*, Pediatrics vol. 137, no. 3 (2016).

⁸⁷ *Ibid.*

⁸⁸ Moreover, Dr. Josephson has previously been found to be inconsistent and unreliable as an expert witness. *See Aid for Women v. Foulston*, 427 F.Supp. 2d 1093 (2006).

⁸⁹ Josephson Depo., pp. 126:16-127:22.

“delusional” going forward, and admitted that medical professional groups would have “trouble” with his opinion regarding delusions;⁹⁰

- Dr. Josephson testified (and put in his Report) that he was aware of “studies” “in their infancy” regarding the impact on cisgender students of a transgender student in the restroom – but when asked to identify the studies he admitted, “I’m not aware of any being done right now” and that he has not done any.⁹¹ and
- Dr. Josephson testified that he “referred one young man” identifying as transgender to “another psychiatrist in town who has claimed some specialty expertise” – but when asked for the name of the psychiatrist, testified evasively, “I haven’t got his name yet,” and he would refer “when the [patient’s] mother gets me the name” – but then said there are “two psychiatrists” and he would “pick one.”⁹²

II. LEGAL STANDARD FOR EXCLUDING EXPERT WITNESSES

The admissibility of expert testimony is governed by Rule 702 of the Federal Rules of Evidence. The court may admit the testimony of a “qualified expert” if “(a) the expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.” Fed. R. Evid. 702. The court serves a gatekeeping function to “ensur[e] that an expert’s testimony both rests on a reliable foundation and is relevant to the task at hand.” *Daubert*, 509 U.S. at 597.

Testimony that is deemed either irrelevant or unreliable does not meet the evidentiary standards of the Federal Rules, and should be excluded. *Id.* at 591. In the Eleventh Circuit,

[e]xpert testimony may be admitted into evidence if: (1) the expert

⁹⁰ *Id.*, pp. 239:1-242:1.

⁹¹ *Id.*, pp. 72:22-73:17.

⁹² *Id.*, pp. 97:2-22; 98:2-10.

is qualified to testify competently regarding the matters he intends to address; (2) the methodology by which the expert reaches his conclusions is sufficiently reliable as determined by the sort of inquiry mandated in *Daubert*; and (3) the testimony assists the trier of fact, through the application of scientific, technical, or specialized expertise, to understand the evidence or determine a fact in issue.

City of Tuscaloosa v. Harcros Chemicals, Inc., 158 F.3d 548, 562 (11th Cir. 1998).

The party offering the expert has the burden to satisfy these elements by a preponderance of the evidence. *Rink v. Cheminova, Inc.*, 400 F.3d 1286, 1292 (11th Cir. 2005).

A court may conclude that there is simply “too great an analytical gap between the data and the opinion proffered” to qualify the expert’s testimony as reliable. *General Electric Co. v. Joiner*, 522 U.S. 136, 146 (1997). In other words, an opinion is not translated into fact simply because it is spoken by someone who claims to be an expert. *See Textron Inc. v. Barber-Colman Co.*, 903 F. Supp. 1558, 1564 (W.D.N.C. 1995) (stating that “an expert’s opinion ‘must be . . . an opinion informed by the witness’ expertise[,] rather than simply an opinion broached by a purported expert”). Experts can, and often do, harbor opinions about the validity of scientific research that is not borne out by the results of that research or by the consensus of the scientific community; when presented with such unsubstantiated opinion testimony, the court must evaluate its value under Rule 403. *Daubert*, 509 U.S. at 595.

III. LEGAL ARGUMENT

A. Dr. Josephson is Not Qualified as an Expert on Any Issue Before the Court

“[A] witness may be qualified as an expert by virtue of his ‘knowledge, skill, experience, training, or education.’” *Quiet Technology DC-8, Inc. v. Hurel-Dubois UK Ltd.*, 326 F.3d 1333, 1342 (11th Cir. 2003). However, credentials are not dispositive when determining qualification. “Expertise in one field does not qualify a witness to testify about

others.” *Lebron v. Secretary of Florida Dept. of Children and Families*, 772 F.3d 1352, 1368 (11th Cir. 2014) (a psychiatrist was prevented from opining on rates of drug use in an economically vulnerable population because he had never conducted research on the subject, and instead relied on studies to form his opinion). “A scientist, however well credentialed he may be, is not permitted to be the mouthpiece of a scientist in a different specialty.” *Dura Automotive Systems of Indiana, Inc. v. CTS Corp.*, 285 F.3d 609, 614 (7th Cir. 2002). A well-credentialed individual may nonetheless be disqualified if he does not “propose to testify about matters growing naturally and directly out of research he had conducted independent of the litigation.” *Lebron*, 772 F.3d at 1369.

In this case, Dr. Josephson lacks proficiency, much less expertise via knowledge, skill, experience, or education, in treating transgender patients or regarding gender dysphoria. He admitted under oath that he lacks expertise in these areas. Assuming *arguendo* that Dr. Josephson could be an expert “in the assessment and treatment of adolescents” generally, that does not render him an expert in any field pertinent to the issues in this case, such as assessment and treatment of gender dysphoria, treating transgender youth, or issues relating to gender identity. *See, e.g., Lebron*, 772 F.3d at 1368. None of his proposed testimony flows from any knowledge, research, study, or experience that he has. *Id.* Worse still, Dr. Josephson drastically exaggerated the very limited clinical experience he has regarding transgender patients, admitting that the credentials he put forth in his Report were untrue.

Dr. Josephson should be excluded because he is unqualified as an expert witness in this case and his clinical experience with children and adolescents generally does not translate to expertise regarding gender dysphoria or transgender youth. *Quiet Technology*,

326 F.3d at 1342. Dr. Josephson has strong opinions on the nature of transgender youth, but he is no expert. Defendant cannot meet its burden to show that Dr. Josephson is qualified to testify competently on matters before the Court. *City of Tuscaloosa*, 158 F.3d at 562.

B. Dr. Josephson's Opinions and Testimony are Unreliable

Even if Josephson is found to be qualified (which he is not) his testimony must be excluded because it is unreliable. Reliability “concerns whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning or methodology properly can be applied to the facts in issue.” *Seamon v. Remington Arms Co., LLC*, 813 F.3d 983, 988 (11th Cir. 2016). In making this determination, courts consider a variety of factors, including whether the purported expert's theory has been tested, whether it has been subjected to peer review and publication, and whether the theory has been generally accepted in the scientific community. *Daubert* at 593-94; *see also Rink*, 400 F.3d at 1292. Courts may properly consider whether the expert's methodology “has been contrived to reach a particular result.” *Rink*, 400 F.3d at 1293, n. 7. The court's role is to assess “whether the evidence is genuinely scientific, as distinct from being unscientific speculation.” *Chapman v. Procter & Gamble Distributing, LLC*, 766 F.3d 1296, 1306 (11th Cir. 2014).

Dr. Josephson based his “unscientific speculation” on “untested” theories, uncorroborated anecdotes, assumptions that are obsolete, flawed, unethical, and expressed opinions based upon “unsettled science.” *Chapman*, 766 F.3d at 1306. His opinions lack the markers of reliability necessary for them to be admitted as expert testimony. Dr. Josephson conducted *no studies or research*, employed no methodology or scientific basis to reach any of his opinions. In addition, his opinions regarding transgender people, as he admits, are “in

the minority” and squarely at odds with all medically accepted standards of care. His opinions on major topics, such as treatment protocols, have been *rejected by every legitimate authority in the areas of gender dysphoria and transgender healthcare* including the American Medical Association, WPATH, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, and the Endocrine Society. Dr. Josephson also misstated and “contrived” the findings of others’ studies and changed his testimony, initially stating there were studies “in their infancy” to support his theory and then admitting there were *none*. *Rink*, 400 F.3d at 1292.

Based on his sworn testimony to the contrary, Defendant simply cannot meet its burden to prove that Dr. Josephson’s theories have been tested, subjected to peer review and publication, or that they are generally accepted in the scientific community – they decidedly have not been tested and are rejected by the scientific community. *Daubert* at 593-94; *Rink*, 400 F.3d at 1292.

Perhaps the main opinion of Josephson’s that is directly at odds with accepted medical protocol (and which cuts to the heart of this case) is that Defendant’s bathroom policy is “sound” because it separates students by their “biological sex.” This statement is unreliable, untested, and against the Endocrine Society Guidelines that expressly state that the terms “biological sex” and “biological male” or “biological female” should be avoided because they are imprecise.

Additionally, Dr. Josephson’s case-specific opinions (including regarding Plaintiff) must be excluded because Dr. Josephson lacks knowledge “of facts which enable him to express a reasonably accurate conclusion as opposed to conjecture or speculation.” *Jones v.*

Otis Elevator Co., 861 F.2d 655, 662 (11th Cir. 1988). Dr. Josephson lacks basic knowledge of facts about Drew, Nease High School, or any purported concerns or justifications for Defendant’s exclusionary bathroom policy. Dr. Josephson cannot express a “reasonably accurate conclusion” on these points. *Id.* Dr. Josephson never spoke to, examined, evaluated, or treated Plaintiff; he lacks knowledge regarding Drew’s medical treatment and transition. Based these facts, Dr. Josephson has no basis to render any opinions germane to this case.

Dr. Josephson lacks a basis on which to offer a clinical opinion in this case because he has not interviewed Drew, his family, or providers in order to provide a diagnosis. In his words, his opinion is “not based on a clinical examination.” Nonetheless, Dr. Josephson is attempting to offer a clinical opinion anyway – that Defendant’s policy is not distressing Drew. Dr. Josephson purports to rely *solely* upon YouTube videos of Drew to opine that Drew has suffered no harm. There is no credible basis to accept an opinion from Dr. Josephson when the entirety of his opinion is predicated on his viewing of a few social media videos that Drew posted and his general belief that “any child” (interpreted to mean every child) should be content using a gender-neutral bathroom.⁹³ It is hard to fathom how a psychiatrist cannot appreciate how someone in Drew’s situation would react to being required to use a gender-neutral restroom when his gender is not neutral: he is a boy and should be permitted to use the boy’s restroom along with the other male students.

Moreover, Dr. Josephson’s reasoning and methodology are not scientifically valid and he lacks a basis to provide reasonably accurate conclusions. *Jones*, 861 F.2d at 662;

⁹³ If that were the case, then the Defendant should require all sex-assigned at birth females and sex-assigned at birth males (cisgender) students to use the gender-neutral restrooms, as that is consistent with their own expert’s opinion.

Seamon, 813 F.3d at 988. *Seamon*, 813 F.3d at 988. Dr. Josephson’s opinion regarding the policy at issue is based on nothing more than his musings, as he did not meet with Drew or his family, failed to speak to his treating physicians, and does not regularly treat transgender individuals or those with gender dysphoria; he simply thinks it should not bother Drew. That is not opinion that passes the *Daubert* test, however.

C. Josephson’s Testimony Will Not Assist the Trier of Fact

The helpfulness of expert testimony is primarily a question of relevance. “[I]f an expert opinion does not have a valid scientific connection to the pertinent inquiry it should be excluded because there is no fit.” *Seamon*, 813 F.3d at 988 (quotations omitted). Under Rule 403, evidence which is nominally relevant may nonetheless be excluded if its probative value is substantially outweighed by a danger of, among other things, confusing the issues. “[A] judge assessing a proffer of scientific testimony under Rule 702 should also be mindful of other applicable rules [including Rule 403].” *Daubert* at 595

Dr. Josephson’s testimony, entirely unmoored as it is from the recognized scientific consensus or medical standards of care, will only serve to confuse the issues in dispute and mislead the trier of fact by representing that one man’s conjecture is an accepted alternative psychiatric theory. Dr. Josephson’s opinions provide no guidance or specific expertise that would be useful for the trial court in analyzing the actual issues presented. His opinions shed no light on the relevant legal and factual issues confronted by this Court. Given that Dr. Josephson has no basis to contradict the established medical guidelines (and having never even met Drew), there is no predicate for the introduction of his testimony in this case.

Additionally, Dr. Josephson's opinions are internally inconsistent, which further undermines their usefulness to the Court. As the District Court of Kansas ruled, with regard to Dr. Josephson's expert testimony in *Aid for Women v. Foulston*⁹⁴, this Court should also find that Dr. Josephson's testimony is inconsistent and unreliable. The *Foulston* court noted the "contradiction" that Dr. Josephson testified, "claiming to believe all underage sexual activity is inherently injurious," but "Dr. Josephson personally does not report all such activity." *Id.* at 1110. So too here, where Dr. Josephson *claims* in his testimony and at the Heritage Foundation to believe that affirming a child's gender identity is "neglect" – yet he has never reported anyone who affirmed a child's identity to protective services or attempted to stop gender-affirming medical treatment at the Gender Clinic.⁹⁵ As explained above, Dr. Josephson changed his testimony and opinions repeatedly during his deposition, and admitted to several untruths contained within his own Report. Given Dr. Josephson's inability to present consistent testimony throughout the course of one deposition or accurately represent his experience, it cannot be expected that his opinions will remain constant. Therefore, the Court should find that Dr. Josephson's testimony is inconsistent, unreliable, and unhelpful.

IV. Conclusion

Plaintiff Drew Adams respectfully requests that this Court enter an order precluding Dr. Josephson from testifying or otherwise offering any expert opinions at trial.

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⁹⁴ 427 F. Supp. 2d 1093 (D. Kans. 2006).

⁹⁵ Josephson Depo., pp. 294:2-8.

CERTIFICATE OF CONFERENCE PURSUANT TO LOCAL RULE 3.01(g)

Pursuant to 3.01(g) of the Local Rules of the Middle District of Florida, the undersigned certifies that counsel for the Plaintiff has conferred with the attorneys representing Defendant regarding the relief requested in the motion. The parties were unable to reach a resolution and Defendant's counsel does not consent to the relief requested.

Dated this 6th of December, 2017.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 6, 2017, the foregoing motion was filed electronically using the Court's ECF system, which will provide electronic notice to all counsel of record, including:

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UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, et al.,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS
COUNTY, FLORIDA,

Defendant.

No. 3:17-cv-00739-TJC-JBT

**DECLARATION OF NATALIE NARDECCHIA IN SUPPORT OF PLAINTIFF'S
MOTION TO PRECLUDE DR. JOSEPHSON FROM TESTIFYING AND
OFFERING ANY PURPORTED EXPERT OPINION IN THIS MATTER**

I, Natalie Nardecchia, pursuant to 28 U.S.C §1746, declare as follows:

1. I am over the age of eighteen (18) and make this declaration of my own personal knowledge, and, if called as a witness, I could and would testify competently to the matters stated herein.

2. I am an attorney with Lambda Legal Defense and Education Fund, Inc., and counsel for Plaintiff Drew Adams, by and through his next friend and mother, Erica Adams Kasper, in this litigation. I am licensed to practice law in the State of California, and was admitted *pro hac vice* to practice before this Court.

///

3. Attached hereto as Exhibit A is a true and correct copy of the Deposition Transcript of Allan M. Josephson, taken November 28, 2017 in Louisville, Kentucky.

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

Executed this 6th day of December, 2017



Natalie Nardecchia

CERTIFICATE OF SERVICE

I hereby certify that on December 6, 2017, the foregoing Declaration was filed electronically using the Court's ECF system, which will provide electronic notice to all counsel of record, including:

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EXHIBIT A



KENTUCKIANA
— COURT REPORTERS —

NO. 3:17-cv-00739-TJC-JBT

DREW ADAMS, ET AL.

V.

THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA

DEPONENT:

ALLAN M. JOSEPHSON, MD

DATE:

November 28, 2017



✉ schedule@kentuckianareporters.com

☎ 877.808.5856 | 502.589.2273

1 UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF FLORIDA
3 JACKSONVILLE DIVISION
4 NO. 3:17-cv-00739-TJC-JBT

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6 DREW ADAMS, ET AL.,
7 PLAINTIFFS

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9 V.

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11 THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA,
12 DEFENDANT

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23 DEPONENT: ALLAN M. JOSEPHSON, M.D.

24 DATE: NOVEMBER 28, 2017

25 REPORTER: MEGAN BROWN

1 APPEARANCES

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9
10 ALSO PRESENT: ALEX GLASNOVIC, VIDEOGRAPHER
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1 STIPULATION

2
3 The VIDEO deposition of ALLAN JOSEPHSON, M.D. taken at
4 KENTUCKIANA REPORTERS, 730 WEST MAIN STREET, SUITE 101,
5 LOUISVILLE, KENTUCKY 40202 on TUESDAY, the 28th day of
6 NOVEMBER, 2017 at approximately 9:01 a.m.; said
7 deposition was taken pursuant to the FEDERAL Rules of
8 Civil Procedure. It is agreed that MEGAN BROWN, being a
9 Notary Public and Court Reporter for the State of
10 Kentucky, may swear the witness and that the reading and
11 signing of the completed transcript by the witness is
12 not waived.

1 PROCEEDINGS

2
3 VIDEOGRAPHER: Okay. We are now on record. My
4 name is Alex Glasnovic. I'm the video technician
5 today, and Megan Brown is the court reporter. Today
6 is the 28th day of November, 2017. The time is 9:01
7 a.m. We are at the offices of the Kentuckiana Court
8 Reporters located in Louisville Kentucky to take the
9 deposition of Allan Josephson, M.D. in the matter of
10 Drew Adams, et al. v. the School Board of St. Johns
11 County, Florida, pending in the United States
12 District Court for the Middle District of Florida,
13 Jacksonville Division, Number 3:17-CV-00739-TJC-JBT.
14 Will Counsel please identify themselves for the
15 record?

16 MS. NARDECCHIA: Good morning. Natalie
17 Nardecchia for the plaintiff.

18 MR. KOSTELNIK: Good morning. Kevin Kostelnik
19 for the defendant.

20 MS. ALTMAN: Jennifer Altman from Pillsbury
21 Winthrop Shaw Pittman for the plaintiff.

22 MR. PINGERRA: Anthony Pingerra for the
23 plaintiff.

24 VIDEOGRAPHER: Thank you. Dr. Josephson, will
25 you please raise your right hand to be sworn in by

1 the reporter?

2 COURT REPORTER: Do you solemnly swear or
3 affirm that the testimony you're about to give will
4 be the truth, the whole truth and nothing but the
5 truth?

6 THE WITNESS: I do.

7 COURT REPORTER: Thank you.

8 MR. KOSTELNIK: Natalie, are you okay with just
9 saying "form" for any objections rather than "object
10 to form"?

11 MS. NARDECCHIA: Sure.

12 MR. KOSTELNIK: Just to speed things up.

13 MS. NARDECCHIA: That's fine.

14 MR. KOSTELNIK: Okay.

15 DIRECT EXAMINATION

16 BY MS. NARDECCHIA:

17 Q Okay. Good morning, Dr. Josephson. Could you
18 please state and spell your full name for the record?

19 A Allan Mark Josephson. A-L-L-A-N, M-A-R-K,
20 J-O-S-E-P-H-S-O-N.

21 Q Now, the oath that you've just taken is the
22 same that you would take as if you were in the court of
23 law. Do you understand that you're testifying under
24 penalty of perjury?

25 A Yes.

1 Q Okay. You've had your deposition taken
2 before, correct?

3 A Yes.

4 Q How many times?

5 A Oh, boy. Maybe ten. Testing my memory. I'm
6 just estimating ten.

7 Q Okay. So I'll just be quick then in going
8 over the deposition ground rules. So everything that's
9 being said in the room today is being transcribed by the
10 court reporter. So please speak clearly, audibly so
11 that she can take down everything that's being said.
12 Please give a verbal response such as "yes" instead of
13 "uh-huh" or nodding. And please also wait for me to
14 finish asking my question even though you may know what
15 I'm going to ask. And sometimes I take a minute to
16 finish my question. Just let me finish before you
17 respond and I will wait for you to answer before I ask
18 you another question, okay?

19 A (NO VERBAL RESPONSE.)

20 Q Yes?

21 A Yes.

22 Q Okay. I will take it that you understand my
23 question if you respond to it. So if you don't
24 understand my question, let me know.

25 A Okay.

1 Q Okay. And if I've asked you a question, I'd
2 prefer that you answer my question before you take a
3 break if you need to take one, okay?

4 A Okay.

5 Q Is there any reason, either your own physical
6 health or any medications you may be under, that would
7 prevent you from giving your best testimony today?

8 A No.

9 Q Okay. Can you please start off by telling me
10 all the opinions you intend to offer in this case?

11 A That's a broad question. Could you focus that
12 a little more? I mean...

13 Q Not really.

14 A Well, I'm here to provide information related
15 to the diagnosis of gender dysphoria, how it might
16 develop, how I as a physician and psychiatrist go about
17 identifying these problems, helping youth and their
18 families with these problems. And that would be the
19 main thing. The nature of the condition and how it's
20 treated and how that information might be relevant to
21 the attorneys working on this case.

22 Q Okay. You mentioned the nature of the
23 condition. Which condition are you referring to?

24 A Gender dysphoria.

25 Q Have you ever spoken to the plaintiff in this

1 **case, Drew Adams?**

2 A I have not.

3 **Q You never examined him?**

4 A I have not examined him.

5 **Q You've never evaluated him?**

6 A No.

7 **Q Never treated him?**

8 A No.

9 **Q Have you asked for an independent medical exam**
10 **of Drew Adams?**

11 A No.

12 **Q Do you believe that speaking to Drew Adams**
13 **would have enabled you to provide more accurate opinions**
14 **in this case?**

15 A The information that I've had has been very
16 useful and helpful. Speaking to a patient always
17 clarifies things. But I'm more than able to offer an
18 opinion on this case.

19 **Q Did you request of counsel for the school**
20 **board to interview or meet with Drew?**

21 A No.

22 **Q Okay. Did anyone tell you you could not meet**
23 **or evaluate Drew Adams?**

24 A No.

25 **Q And --**

1 A It's my understanding if, you know, I don't
2 have a license in the state of Florida and that
3 precludes doing any clinical practice in the state of
4 Florida. If someone was going to fly him up here, that
5 would have been a different issue. But it never came
6 up.

7 **Q So your understanding is that since you don't**
8 **have a license in Florida, you're precluded from doing**
9 **what in the state of Florida?**

10 A Practicing medicine in any way. In other
11 words, treating a patient, assessing a patient, that
12 kind of thing.

13 **Q What precludes you?**

14 A Usually state law.

15 **Q Which law?**

16 A Laws that have to do with practicing medicine.
17 I don't have a license to practice medicine in Florida.

18 **Q You could have spoken to Drew Adams, though,**
19 **right?**

20 A Well, it would have been an interesting
21 question. I suppose I could have but what would the
22 nature of that been would be the question. I, as a
23 psychiatrist, why would I speak to him unless it was in
24 a doctor-patient relationship. I'm not an attorney. Put
25 it that way.

1 Q What date did you submit your -- well, let me
2 strike that. You submitted your expert report in this
3 case on October 2, 2017; is that right?

4 MR. KOSTELNIK: Form.

5 A That's correct.

6 Q All right. And when you submitted your expert
7 report had you reviewed any of Drew's medical records?

8 A Yes, I had seen some of them at that point.

9 Q Are you sure?

10 A I'm trying to think. October 2nd. I may not
11 have. I may not have. That report was quite general in
12 nature regarding gender dysphoria and I had seen records
13 on the case about the school district's policies and so
14 forth. But I don't think at that point I had seen his
15 medical records.

16 Q Did you speak with any of Drew's treating
17 physicians at any point?

18 A No.

19 Q Did anyone advise you you could not speak to
20 his treating physicians?

21 A No.

22 Q Do you believe speaking to his treating
23 physicians would have enabled you to provide more
24 accurate opinions in this case?

25 A Perhaps. The materials that I saw and that

1 I've seen subsequently, I've seen the patient himself on
2 self-produced videos and so forth. So I've got a lot of
3 information. If you talk with a physician who treated
4 him, it might have given more information.

5 **Q Which videos have you seen of Drew Adams?**

6 A Four or five of them that he produced. I
7 think he was talking about various aspects of his gender
8 dysphoria, his activism, these types of things.

9 **Q Okay. But you hadn't seen those videos prior**
10 **to submitting your report in this case?**

11 A No.

12 **Q Have you ever spoken to Drew's mother?**

13 A No.

14 **Q His father?**

15 A No.

16 **Q Have you ever evaluated them?**

17 A No.

18 **Q Do you know if Drew has any siblings?**

19 A I believe he does. But I'd have to check
20 that. I'm not sure.

21 **Q You can't say for the record as you sit here**
22 **today if he has a brother or sister or how many?**

23 A Not with certainty, no.

24 **Q Are you offering an opinion in this case on**
25 **whether Drew Adams is transgender?**

1 A No.

2 Q Would you agree with me that Drew Adams is a
3 boy?

4 A Depends on how you define boy.

5 Q Is there any definition of boy that you would
6 agree -- sorry -- that you would agree Drew Adams is?

7 MR. KOSTELNIK: Form.

8 A Drew Adams is a genetic born natal female. At
9 this point in his life, he believes he is male.

10 Q And his doctors also say that he is male,
11 correct?

12 MR. KOSTELNIK: Form.

13 A Well, he's had a number of different doctors.
14 I think some have been involved with hormone treatments,
15 that kind of thing. And they are helping him transition
16 to be male. But he is a genetic natal female.

17 Q Do you know where Drew is in his transition?

18 A He certainly had hormones. I think he has
19 been -- from what he said, he's been desiring that he
20 has more male characteristics develop, i.e., facial hair
21 and so forth. So the hormonal treatments are going on.
22 And I'm not exactly sure where the rest of the
23 transitioning treatments are.

24 Q Okay. So you don't know whether or not he's
25 had any surgeries?

1 A I'm not sure the extent of that, no.

2 Q Okay. So you said Drew believes he is male.
3 So I take it you do not believe he is male?

4 A He is a genetic female who feels that he is
5 male.

6 Q Do you accept that when people transition at
7 some point they are the other gender?

8 MR. KOSTELNIK: Form.

9 A They believe they're the other gender. But
10 they're not the other sex.

11 Q Even if they have legal documents saying that
12 they were now transitioned to a different gender?

13 MR. KOSTELNIK: Form.

14 A Well, the -- and I'm not sure where that
15 process is at, either. But once that legal process took
16 place, then he could be called a male.

17 Q As you sit here today, do you know whether or
18 not Drew Adams has legal documents identifying him as
19 male?

20 A I think he has. He's under 18, which would be
21 a little unusual in some states. But I think there have
22 been moves toward that, from what I've seen or heard him
23 say on the video.

24 Q Do you know for --

25 A But that would make -- legally then that would

1 make him had a male, yes.

2 **Q Okay. So do you know whether his driver's**
3 **license says he's male?**

4 A I don't know.

5 **Q Or his birth certificate?**

6 A I think the birth certificate may have been
7 changed.

8 **Q Okay.**

9 A And that would allow him to say then that he
10 -- he is male.

11 **Q And you would accept that?**

12 A Yes. Although I would say that the discussion
13 we're having is going from fact to a feeling. The fact
14 of sex, the fact of his male/female is a fact and that
15 cannot change. And that will remain. Now he has felt
16 that he's female. He is now a legal -- moves to be
17 female -- I'm sorry -- to be male and those should be
18 respected and accepted. And where he's actually at on
19 that journey, I'm not sure I have the full information.

20 **Q You say it should be respected and accepted**
21 **that he's male if he's transitioned?**

22 A Well, once he goes through the legal
23 procedures and made that statement how he presents
24 himself legally to society, yes.

25 **Q Okay.**

1 A Then he would be male.

2 Q And you said the fact is he's natal sex. By
3 that do you mean that his sex when he was born was --

4 A XX, female.

5 Q Female. Okay. And he was identified as being
6 female?

7 A Yes.

8 Q Okay. Did you ever do a chromosome test on
9 Drew Adams?

10 A No. That is usually not indicated and has
11 been for hundreds of years, visual inspection is enough
12 for most people. It is not done in medicine at all
13 unless there's a disorder of sexual differentiation,
14 that kind of thing.

15 Q You said "visual inspection", you meant of the
16 external genitalia?

17 A Physical examination, yeah.

18 Q I'm sorry, of the external genitalia, correct?

19 A That's typically the most standard way of
20 doing it. There may be other things pediatricians do,
21 but a physical exam, yeah.

22 Q The reason I asked if you'd done a chromosome
23 test because as you mentioned XY, which is you're
24 referring to chromosomes, correct?

25 A Right. Yeah. And so that being natal female,

1 he would have XX and then XY is the male pattern, yes.

2 Q But I mean you didn't test to know?

3 A No, no, I did not.

4 Q So it sounds like you agree with me that if
5 someone says that they're male, you use male pronouns;
6 is that right?

7 A That's kind of by convention. It's out of
8 respect for the person. But it doesn't change the
9 biological nature of the individual.

10 Q Okay.

11 A It's what they want to be called and that's
12 what they feel they should be called. And so I will
13 usually respect that, yeah.

14 Q By "biological nature" again you're referring
15 to natal sex, right?

16 A That's correct.

17 Q Okay. Do you have any reason to doubt that
18 Drew identifies as male?

19 A No.

20 Q Do you have any reason to doubt his medical
21 providers attesting that he is male?

22 A No. I believe they've probably done that,
23 yeah.

24 Q But you don't know?

25 A I'm not sure. I mean, the records I -- I

1 think I've seen a couple of attestations they attest
2 that he is now male.

3 Q Are you rendering an opinion as to whether
4 Drew Adams suffers from gender dysphoria?

5 A No, because I haven't examined him.

6 Q Do you agree, then, that it would be improper
7 to offer a diagnosis about a patient that you've never
8 examined?

9 MR. KOSTELNIK: Object to form.

10 A Well, it depends on the context. I think when
11 you take a psychiatrist, for example, in this case me,
12 who has 45 years of experience, has seen thousands of
13 patients, has seen thousands of records and has a broad
14 base in psychopathology, in other words, how to diagnose
15 and treat the problems of youth, and then given the
16 history and given the story and let them look at the
17 records, that's a pretty significant thing. And
18 depending on the accuracy of the records, I would feel
19 comfortable in saying this appears to be that type of
20 patient, but I stop short of saying I know the diagnosis
21 because, of course, I would not have seen him.

22 Q Okay. And just so I'm clear, when you said
23 the kind -- you said one of the things you'd want to
24 look at are the records. You're referring to the
25 person's medical records?

1 A Well, any records. School, medical, that
2 reflect his experience, his statements, the way he
3 presents himself, that kind of thing.

4 Q Do you agree that Drew Adams was diagnosed
5 with gender dysphoria by his medical providers?

6 A Yes.

7 Q Okay. And I noticed -- well, I think based on
8 your own testimony you described your expert report as
9 being general in nature with regard to gender dysphoria.
10 Is that accurate?

11 A Right. It was a broad, broad report about
12 these -- these issues and the particular case as it was
13 presented to me and the documents that I read regarding
14 the complaint, the school's position, the policies and
15 so forth.

16 Q So then are you not offering -- sorry. Let me
17 start over so it's a clear question. So then are you
18 offering any opinions on whether Drew Adams' gender
19 dysphoria has or will persist?

20 A I'm not offering an opinion on that. I mean,
21 I could be asked one and would probably, I think it
22 would be fairly accurate. But I'm not offering it in
23 this case.

24 Q Okay. Are you offering any opinion on whether
25 Drew Adams will cease to identify as being transgender?

1 A No.

2 Q And you're not offering any opinion on the
3 causes of Drew's gender dysphoria; is that also correct?

4 A No. I mean, that is correct.

5 Q Yes. Thank you. Are you offering any
6 opinions about the propriety of Drew's transition-
7 related medical care he's received?

8 A No.

9 Q Are you offering any opinions about Drew's
10 home life or anything about his relationship with his
11 family?

12 A No.

13 Q Are you offering any opinions that are
14 specific to the facts of this case?

15 A Yeah. I would be offering the opinion that
16 the school district's policy appears to have responded
17 to his needs. And I have the opinion that, you know,
18 they're not forcing him to go to a female restroom.
19 They're giving him close proximity to a gender-neutral
20 restroom. And that any statements that he is going
21 through significant stress, harm, irreparable harm,
22 these kinds of terms, I'm not supporting that by my
23 opinion.

24 Q Okay.

25 A He seems to be quite comfortable in his

1 current status.

2 **Q What do you mean he's quite comfortable in his**
3 **current status?**

4 A Based on the videos I saw, his ease with
5 himself, his ease in presenting his story, he didn't
6 present himself as one under a great deal of stress. So
7 I would have that opinion.

8 **Q Do you know if -- and you're basing that on**
9 **videos you saw?**

10 A That's the only -- yeah. That's the only
11 database I saw. And then -- yeah, that would be it,
12 yeah.

13 **Q Do you know if the videos you saw were filmed**
14 **at a time after he had received gender-affirming**
15 **treatment?**

16 A Oh, yeah. I think they're pretty recent. And,
17 of course, his treatment's been going on for a couple of
18 years, so, yeah. It would be after he had been treated.

19 **Q Okay. So what do you understand the school**
20 **district's policy to be that you were just talking**
21 **about?**

22 A Well, they have -- you made bathrooms readily
23 available that he -- that he could go to. They're not
24 forcing him against his felt gender. They're
25 accommodating that way. And I believe they're using

1 pronouns he prefers. And have gone to those lengths to
2 make him feel comfortable.

3 Q Have you been to Drew's high school?

4 A No.

5 Q So you don't -- you haven't, for instance,
6 walked in his shoes, so to speak, from his classroom to
7 the gender-neutral restrooms, correct?

8 MR. KOSTELNIK: Form,

9 A That is correct, yes.

10 Q So you're basing your opinion that there's --
11 the school has offered restrooms that are in close
12 proximity on what?

13 A Just reading their policy and that would
14 basically be it.

15 Q Reading the school district's policy?

16 A Right. What they did.

17 Q Well, can you tell me exactly what you read
18 about the school policy?

19 A Well, that they've provided restrooms for him
20 that he could go to, that anyone could go to, not just
21 him, that are gender neutral and that they're within
22 proximity. The -- yeah.

23 Q So you're -- well, strike that. Do you know
24 how far exactly from Drew's classrooms the gender-
25 neutral restrooms are?

1 A Not exactly. I do know that in the expert
2 report that I read, it was stated that he would take a
3 great deal of his classroom time to have to go there and
4 that just doesn't seem to be true.

5 Q And you base that again on the school
6 district's policy that you read?

7 A Right, yeah.

8 Q Okay. So since you've never evaluated Drew or
9 even spoken to him, how do you know that the school
10 district's policy has responded to his needs?

11 A Well, it's a standard policy that would
12 respond to any child's need in his situation. He's
13 provided a place to go to the restroom. It's not
14 stressful. It's gender neutral. And he's not forced to
15 go against his felt gender position.

16 Q What is gender position?

17 A There's still a gender. He's not asked to go
18 to a female restroom. He believes he is male and he's
19 been given restrooms to go to with respect to that.

20 Q You said it was not stressful for Drew to go
21 to gender-neutral restrooms. What do you base that on?

22 A Maybe it would be better to say it's hard to
23 conceive of how it would be stressful to go to a gender-
24 neutral restroom when many other students go to that as
25 well.

1 **Q It's hard to conceive, but you never talked to**
2 **him about it, right?**

3 MR. KOSTELNIK: Object to form.

4 A No, I did not.

5 **Q And so --**

6 A This is not based on a clinical examination,
7 no.

8 **Q Okay. It's hard for you to conceive of that,**
9 **right?**

10 A Right. After -- yeah. I can see how it would
11 be stressful to go to a female restroom as he has moved
12 away from being female. But to go to a restroom that's
13 not identified either one, it's by definition neutral,
14 I'm not sure how that would be stressful.

15 **Q Do you know what social transition means?**

16 A Yes.

17 **Q Can you explain what it is?**

18 A Well, it means that the individual who has a
19 natal biologic sex and has determined and felt -- I
20 shouldn't say determined, but has felt that they're the
21 opposite sex and desires to live in that manner, then
22 goes through stages and is helped by those around him or
23 her to adopt a gender that's not aligned with natal sex.
24 So that means such things as pronoun change, dress,
25 helping them identify -- as in this case, identify as --

1 as male. And all the social things that are associated
2 with gender that individuals helped to take those
3 various behaviors, as encouraged in those behaviors, to
4 the identified felt gender. So that's a rough social
5 transition description.

6 **Q Isn't going to a restroom that corresponds**
7 **with one's gender identity part of social transition?**

8 A Yeah, it would be part of that, yeah.

9 **Q And isn't that part of the prescribed medical**
10 **treatment for some transgender youth?**

11 A If it can be achieved in the context of a
12 culture society school, sure. But they're often
13 competing forces, yeah.

14 **Q Okay. Do you know if that was part of Drew**
15 **Adams' medical treatment, that he be allowed to use**
16 **restrooms that correspond with his gender identity?**

17 MR. KOSTELNIK: Form.

18 A I'm sure that's been recommended, sure.

19 **Q Do schools generally try to follow what a**
20 **medical provider's treatment plan is for students?**

21 A Generally. But not --

22 MR. KOSTELNIK: Form.

23 A -- if it affects many others that are
24 students. Schools have to deal with multiple students,
25 multiple demands, multiple agendas. And most schools,

1 and I think this one is in that category, do everything
2 they can to meet the individual needs of a child. But
3 the individual needs of a child often come in contact
4 with the individual needs of many other children.

5 **Q Can you think of any other example of where a**
6 **school will reject a student's medical provider's**
7 **prescribed treatment in order to accommodate other**
8 **students besides that student who needs the medical**
9 **treatment?**

10 A I can't -- I can't think of one offhand. But
11 I'm sure there are things that have to do with physical
12 exercise, diet. The many different things that restrict
13 children. One example is children who have peanut
14 allergies, for example. It's not uncommon then for
15 peanuts to be restricted from a classroom and then you
16 have a situation where one child wants peanuts and the
17 other one can't have them. And you have countless
18 situations in large institutions of which schools are a
19 part, where the needs of one individual go against
20 another group. And you try to sort that out. And
21 school districts do the best they can in that regard.

22 **Q Well, okay. In the example of a severe peanut**
23 **allergy, though, wouldn't the classroom, for instance,**
24 **and I think this is just a real-life example, if you**
25 **student has a severe peanut allergy wouldn't the**

1 classroom and the teacher say don't bring in peanut
2 butter cupcakes for all the students in the class. I
3 mean, to make sure that that student is safe?

4 A Well, they might do that, yeah. And then they
5 may get calls from a parent that says my son loves his
6 peanut cupcakes and he lives for that and he really
7 needs that to feel socially well-adjusted and study more
8 effectively. And then the teacher would have to decide
9 what to do. And I think we could come up with countless
10 examples of that.

11 Q Are you offering an opinion that Drew, a
12 16-year-old boy, should resist urinating or to use your
13 word, hold it?

14 A No. I think he needs to go to the bathroom
15 when he needs to, yeah. And the bathroom should be
16 readily available.

17 Q Okay. You put that in your rebuttal report,
18 though, right?

19 A I can't remember exactly how I put that. But,
20 no, I think the issue was, if I recall, the expert
21 witness stated that he's missing 25 percent of his
22 school day because he has to be going around the school
23 to try to find a classroom -- I'm sorry, a bathroom. And
24 clearly, resisting urinating can happen. I think that
25 was the context of my statement. And younger children

1 do that for a period of time until they can find a
2 restroom. And it is not the most difficult thing in the
3 world to do.

4 Q Is it your professional opinion that it would
5 be appropriate medical standard of care to instruct a
6 minor to refrain from using the restroom when they need
7 to urinate?

8 MR. KOSTELNIK: Form.

9 A Well, of course, you wouldn't refrain them
10 from using the restroom. You're encouraged to try to
11 find the nearest restroom as soon as you could. And
12 Drew should be allowed to leave the classroom as soon as
13 he could to go to the restroom.

14 Q Are you offering an opinion on how much time
15 it takes for Drew to move from his classrooms to the
16 gender-neutral restrooms in the school?

17 A No.

18 Q What if Drew's sitting in class and the
19 nearest restroom for him is the boys' restroom? He
20 should bypass that one and walk all the way to a gender-
21 neutral restroom?

22 A I don't know what "all the way" means.

23 Q Right, because you've never been there, right?

24 A No. But, yeah, he would then, it would be his
25 choice, yeah, to bypass the boys' restroom and find the

1 nearest gender-neutral restroom.

2 **Q It would be his choice?**

3 A Yeah. And I recognize that he would resist,
4 would feel uncomfortable in his current state to go to
5 the boys' restroom. I mean, the boys restroom that he
6 couldn't under current school policy go to. So he'd
7 have to go to one that the school would allow him to.
8 But it's my understanding, and, again, I'm not sure of
9 all their rapid develops in this case, but the school
10 has made efforts to have a restroom that's somewhat
11 close.

12 **Q You mentioned earlier that you would have to**
13 **account for competing forces in determining if he would**
14 **-- if a school district would comply with a student's**
15 **medical provider's treatment or not. What competing**
16 **forces were you referring to?**

17 A Well, the needs of other students. I should
18 be specific. If you're managing a school, as I
19 understand this is a fairly large school, there would be
20 various, maybe a better word would be competing
21 interest, demands, and so forth.

22 **Q So is it your opinion that you have to balance**
23 **the competing needs when addressing whether or not to**
24 **accommodate a student's medical treatment?**

25 A Medical treatments are all on a spectrum, in

1 some ways relative. This is part of a treatment plan
2 that has been increasingly used in transgender
3 transitions as in this case. And people most of the
4 time try to support a student.

5 But in medicine, there are many times where
6 one cannot institute a treatment because it's
7 contraindicated when medicine can't be used because
8 they're on a different type of medicine which would
9 counteract. And so the physician needs to judge at what
10 point does one pursue a treatment. Many times surgeries
11 are recommended and it's hard to proceed because there's
12 a contravening position. So making a medical treatment
13 plan recommendation is not an all or none position.

14 In Drew's case it would be helpful if the
15 treatment plan could be followed. But if it can't or
16 couldn't for some of these reasons that we're talking in
17 and around about, it's not going to harm him
18 irreparably.

19 **Q What do you base that on?**

20 A Forty years of adolescent psychiatry.

21 **Q Anything else?**

22 A I think that's a lot.

23 **Q Okay. But nothing else?**

24 A No. Just because a child says something is
25 difficult doesn't mean it's harmful.

1 Q Well, he said it's more than different, right?

2 A I'm not sure what you're referring to.

3 Q Do you have any understanding of what this
4 experience of being denied the restroom that corresponds
5 to your gender identity has meant for Drew Adams?

6 MR. KOSTELNIK: Form.

7 A I think it's difficult. I think he perceives
8 it as difficult. He may even perceive it as
9 catastrophic. I'm just saying from a child development,
10 child psychiatry, adolescent psychiatry perspective.
11 There's a range of problems and this is not an
12 irreparable harm situation.

13 Q Okay. And have you done any peer reviewed
14 research or studies on whether denying a transgender
15 youth the restroom that corresponds to their gender
16 identity --

17 A What studies have --

18 Q -- Excuse me -- will have harm on them?

19 MR. KOSTELNIK: Form.

20 A No. And those studies haven't been done.

21 Q Okay. So you have not done anything?

22 A I have not done studies on that and no one
23 else has, either.

24 Q You've never published anything on that topic?

25 A On which topic?

1 Q The impact of denying transgender students the
2 right to use the restroom that corresponds to their
3 gender identity?

4 A I've not done that research, no.

5 Q You've never taken any courses on this?

6 MR. KOSTELNIK: Form.

7 A I've not. That's not how medical education
8 works. You don't take courses on a --

9 Q Okay.

10 A -- specific symptom.

11 Q Have you read -- excuse me. Have you read
12 Drew Adams' deposition transcript?

13 A I've seen it. I've not read it in full.

14 Q Have you read any part of it?

15 A Part of it, yeah.

16 Q Which part?

17 A Just the early introductory part.

18 Q How many pages did you read?

19 A I don't know. Maybe 25, maybe.

20 Q Can you tell me what you remember from that --
21 well, strike that. Are you aware that Drew Adams very
22 much wants to use the boys' restroom because he's a boy?

23 MR. KOSTELNIK: Form.

24 A Yes, I am.

25 Q Have you read the transcript -- the deposition

1 transcript for Erica, his mother?

2 A I have not read that.

3 Q Have you read the transcript for Scott, his
4 father?

5 A I haven't seen that.

6 Q Have you read any deposition -- excuse me --
7 any transcripts in depositions taken in this case?

8 A The depositions of most of the school
9 attendants, the school principal and those would --
10 those would be the ones that I would have read.

11 Q So school district personnel, but not Drew or
12 his parents, correct?

13 A Correct.

14 Q Did you read --

15 A Not in their entirety. But they will be --
16 they will be read by the time I testify.

17 Q Okay. So just to be clear, the only pages
18 from Drew, his mother or father were approximately 25
19 pages of Drew Adams' transcript, correct?

20 A Yeah, right from the beginning, yeah.

21 Q Okay. Have you read the deposition for Dr.
22 Hruz?

23 A I didn't know that was published yet, no.

24 Q Have you spoken to Dr. Hruz about his
25 deposition -- about his deposition?

1 A I've talked with him. Not about his
2 deposition at any length at all.

3 Q But you talked to him a little bit about it?

4 A Yeah.

5 Q When was that?

6 A Earlier in the week. I've been talking to him
7 about some other issues related to management of an
8 academic division and he mentioned that he had his
9 deposition and that was pretty much it. We talked very
10 briefly about that.

11 Q Did he tell you what questions he was asked?

12 A No. He mentioned that there was a focus on
13 his religious beliefs.

14 Q Okay. What did he say -- well, did he say
15 anything else about the deposition?

16 MR. KOSTELNIK: Form.

17 A No.

18 Q Okay. You mentioned you talked to him about
19 an academic -- I'm sorry. What did you say?

20 A On academic leadership administrative
21 questions.

22 Q What is that?

23 A He was chief of a division and I'm chief of a
24 division, an academic center. Questions related to
25 management of the division and so forth.

1 **Q What were the questions that you were talking**
2 **to him about?**

3 A Basically how it was going. He is no longer
4 chief. He's doing his research primarily and it was
5 asking him how that transition had gone for him.

6 **Q Okay. We'll come back to Dr. Hruz. I have**
7 **some more questions about him later. Have you published**
8 **anything regarding gender dysphoria?**

9 A No.

10 **Q Or regarding gender identity?**

11 A No.

12 **Q Regarding transgender health care?**

13 A No.

14 **Q Are you offering an opinion that Drew Adams**
15 **should essentially toughen up and accept being denied**
16 **using the restroom that corresponds to his gender**
17 **identity?**

18 MR. KOSTELNIK: Form.

19 A I wouldn't use the term toughen up, but I
20 would say that when he's in a public high school that
21 has the demands of a public high school and that there
22 are many competing demands of other youth and their
23 needs, that he should recognize that and developing the
24 coping skills that are needed to deal with that. He
25 will soon be a legal adult. He apparently has gone

1 through a legal transition and birth certificate,
2 driver's license, one or the other or both. And that
3 adulthood is looming and he can do that.

4 But to make a massive change which he's made
5 in his life in a fairly short period of time, it takes a
6 while for this to get internalized and accepted into his
7 own identity. And to have immediate changing of
8 everything that is in his school environment is going to
9 be difficult and he needs to learn to cope, to adjust,
10 go to gender-neutral bathrooms until he is ready.

11 **Q What peer review research or studies have you**
12 **analyzed that evaluates impact on transgender youth who**
13 **are not affirmed in their gender identity?**

14 MR. KOSTELNIK: Form.

15 A If youth is not affirmed or not accepted as a
16 person, those studies show that that's not helpful.
17 Everyone needs to be accepted and respected in their --
18 in their own identity. And that would be a general
19 statement from the research.

20 **Q Well, isn't what the school district is doing**
21 **refusing to affirm Drew's gender identity as male by**
22 **denying him the ability to use the boys' restroom?**

23 MR. KOSTELNIK: Form.

24 A Well, life's complicated and he's made a
25 complicated decision and is in an environment, a culture

1 with numerous other -- other youth. And you can be
2 affirmed, as they've done with pronouns and -- and
3 things of that nature, that it may not be entirely
4 feeling affirming to him. But he's on the road to
5 becoming a male and it will happen. So he should be
6 encouraged to think of these very steps.

7 **Q Well, he's already male, though, right?**

8 MR. KOSTELNIK: Form.

9 A Well, he feels he's male, yeah.

10 **Q Well, his legal documents reflect that he's**
11 **male, right?**

12 A That's my understanding. But my point is --

13 **Q Okay.**

14 A -- to make that change and then say the world
15 should change immediately, that's -- he will have to
16 recognize and adjust to these types of things. And he's
17 -- he's in a -- statistically a distinct minority of
18 individuals in the culture and that leads to certain
19 kinds of problems. And people can be caring, as I think
20 when I read the depositions from many teachers, people
21 can respond to him. But some problems still remain. And
22 total affirmation is -- you know, is a goal, but not all
23 of his needs may be met immediately.

24 **Q Do you know how long Drew Adams has been**
25 **trying to use the boys' restroom?**

1 A Well, he changed roughly, I think, the summer
2 of 2015 and I think he was able to use boys' restrooms
3 for a while and then my understanding is then it stopped
4 and now he cannot.

5 **Q Okay.**

6 A The exact length of that time I'm not sure.

7 MR. KOSTELNIK: Let's go ahead and take a
8 break.

9 MS. NARDECCHIA: Okay.

10 VIDEOGRAPHER: It is 9:47 and we are off the
11 record.

12 (OFF THE RECORD)

13 VIDEOGRAPHER: It is 9:58 and we are back on
14 the record.

15 BY MS. NARDECCHIA:

16 **Q Just before we took a break, you mentioned**
17 **that Drew was able to use the boys' restroom for some**
18 **period of time and then it changed at some point. Do**
19 **you know why it changed at some point?**

20 A I don't know the particulars how that evolved.
21 I think it may have been related to some child's
22 concerns, parents' concerns. I don't know.

23 **Q Okay. So have you been advised of any**
24 **complaints about transgender students using the sex**
25 **segregated facility at any of defendant's schools?**

1 A In this particular case?

2 Q **Yeah, within their school district, yes.**

3 A You're talking just globally? Any school
4 or...?

5 Q **So defendant is a school district, right?**

6 A Right.

7 Q **And they have different schools in their
8 school district.**

9 A Okay.

10 Q **So I'm just asking were you advised that there
11 were any complaints made with regard to a transgender
12 student using the sex --**

13 A No.

14 Q **-- segregated --**

15 A No.

16 Q **-- facility? No?**

17 A No. I'm just surmising. I don't know why he
18 could use these facilities and then at some point the
19 school ruled he could not.

20 Q **So, the attorneys for the school district
21 didn't provide you with any evidence that any individual
22 at Nease High School felt their privacy interests were
23 impacted by Drew Adams using the boys' restroom, correct**

24 MR. KOSTELNIK: Form

25 A In terms of evidence, a document, I didn't

1 see. But I believe this is the basis of -- of the suit.
2 The school's responding to things from parents.

3 **Q Which things from parents?**

4 A Concerns about a female being in a -- in a
5 male restroom.

6 **Q Which parents had concerns?**

7 A I don't know.

8 **Q Did any students have concerns?**

9 A I don't know.

10 **Q Okay. So you can't, as you sit here today,**
11 **identify any parents or students who expressed concerns**
12 **about Drew Adams using the boys' restroom in Nease High**
13 **School?**

14 A That's correct.

15 **Q And you didn't see any documents about that?**
16 **About a complaint?**

17 A By a parent?

18 **Q Or a student or anyone?**

19 A I don't believe I did, no.

20 **Q What were you told about the school responding**
21 **to concerns or how did you come to that understanding**
22 **that you believe the school is responding to concerns?**

23 MR. KOSTELNIK: Form.

24 A Well, just putting the case together that he -
25 - he was using this restroom and then at some point it

1 was determined he could not. And so someone decided
2 that. And there was some database that they used. It
3 could have just been in an administrative conference
4 room, but it probably was in response to some public
5 concern, most likely of parents.

6 **Q But you don't have any information on that**
7 **public concern?**

8 A Nothing -- nothing written.

9 **Q Or anything verbal?**

10 A Well, I think in my talking with the attorneys
11 in this case, it seemed that this was initiated by
12 something public, something family, something parents.

13 **Q But you don't have any more specific**
14 **information?**

15 A No, no.

16 **Q So it was all --**

17 A Of who did it, how many people, whether there
18 were students also complaining, I don't know those
19 particulars.

20 **Q So all the information that you just**
21 **referenced was coming from the attorneys representing**
22 **the defendant, correct?**

23 MR. KOSTELNIK: Form

24 A I would have to say yes. I mean, when I asked
25 a general question, what's the nature of the case, how

1 did this arise, I think it was that type of
2 communication.

3 Q So you didn't -- just to be clear, you didn't
4 talk to any students at Nease High School who may have
5 used the boys' restroom with Drew Adams, right?

6 A I did not.

7 Q You didn't talk to any parents of any students
8 who go to Nease High School?

9 A I did not.

10 Q Okay. So it sounds like you -- well, strike
11 that. Did you assume, in offering your opinion, for
12 instance, about competing interests that need to be
13 balanced, that there were concerns expressed by students
14 at Nease High School with Drew using the boys' restroom?

15 A There would have had to have been some event
16 that led to the change in him being allowed to use a
17 boys' restroom and then the move toward providing
18 neutral facilities to enable privacy for some students.

19 Q But you never saw any evidence of any concerns
20 raised that led to preventing Drew from using the boys'
21 restroom, correct?

22 A If you say evidence, letters, emails, no, I
23 did not.

24 Q You never talked to anyone other than Drew's -
25 - sorry, the district's attorneys on that?

1 A That's correct.

2 Q Okay. So can you tell us what exactly the
3 competing -- what specific needs of others at the school
4 conflict with Drew's desire to use the boys' restroom?

5 A Well, it would be individuals who would use
6 the restroom associated with the genetic biological
7 natal sex and being aware that there was an opposite
8 sexed individual in the restroom performing activities
9 of elimination and so forth. So that's -- well, that's
10 it.

11 Q Okay. And with regards to the facts in this
12 case, you're not aware of any individuals using the
13 restroom with Drew Adams who had any concerns?

14 MR. KOSTELNIK: Form.

15 A I'm not aware of any individuals who had,
16 specific individuals.

17 Q Okay. And what would be a specific concern in
18 Drew's -- well, strike that. Did defendant's counsel
19 provide you with any evidence of students who were
20 reluctant to attend school and likely to avoid school
21 restrooms or locker rooms because Drew Adams was using
22 the boys' restroom?

23 A I was not presented with that evidence.

24 Q Did Defendant's counsel provide you with any
25 evidence that Drew Adams use of the boys' restroom

1 **created a "premature sexual experience", to use your**
2 **words, for students?**

3 A Did I use that word for going to the bathroom?

4 **Q You used that in your report. I can show you**
5 **if you need.**

6 A No, that's fine. I'm not sure I would call
7 going to the bathroom a premature sexual experience,
8 except on the event that a person of the opposite
9 genetic sex was observed partially clothed or something.
10 Perhaps that's what I meant.

11 **Q But there's no evidence of that happening in**
12 **this case, right?**

13 A I don't know.

14 **Q You're not aware of any?**

15 A I'm not aware of any. But if Drew goes to the
16 bathroom as a genetic female there may be males who
17 would observe her in some state of not complete dress or
18 whatever. But I'm not aware of any, no. I'm just
19 saying that's the -- that's the context of this.

20 **Q When you just said "her" you were referring to**
21 **Drew Adams?**

22 A He, yes. Drew Adams. It is hard to keep
23 track sometimes.

24 **Q So are you -- based on what you just testified**
25 **to, are you stepping back your opinion that transgender**

1 student using the restroom corresponding to their gender
2 identity creates a "premature sexual experience" for
3 other students?

4 A It could if the unclothed body was observed of
5 Drew, of the female genetic female body observed by a
6 male. It could. And to the extent that, and it's
7 probably what I meant about a sexual experience, means
8 an observing of the opposite sex partially clothed.

9 Q Do you know what -- and you don't know what
10 surgeries Drew has had, correct? If any?

11 A I'm not sure of where that's at in the
12 transition, no. I do know that he hasn't had a penile
13 implant. Whether his breasts have been reduced, I'm not
14 sure. I know that was planned.

15 Q Do you know if Nease High School, the sex
16 segregated facilities have stalls that students can use?

17 A I'm assuming they do.

18 Q If Drew was using the stalls to go to the
19 restroom, no one would be seeing his body?

20 A That's correct.

21 Q Right? Do you know if Drew used stalls when
22 he used the restroom?

23 A I don't know how he uses the restroom, no.

24 Q So you don't have any evidence on that?

25 A No. Whether he uses a urinal or the stall or

1 both, I don't know.

2 Q Okay. What is your specific basis for your
3 opinion that transgender students should be prevented
4 from using the restrooms and locker rooms that
5 correspond with their gender identity?

6 MR. KOSTELNIK: Form.

7 A Should be prevented?

8 Q Uh-huh, yes.

9 A Can you show me the statement you're referring
10 to?

11 Q Well, are you offering an opinion that
12 transgender students -- that's -- well, let me start
13 over. Are you offering an opinion that school districts
14 do the right thing in offering gender-neutral restrooms
15 instead of allowing transgender students to use the
16 restrooms that correspond to their gender identity?

17 MR. KOSTELNIK: Form.

18 A I think offering a gender-neutral bathroom is
19 a balancing move, a compromising move, an intermediate
20 move in a complex situation and one that can meet the
21 needs of both students, with the main difficulty for
22 someone like Drew, meaning that they would like to be in
23 the bathroom of their newly-adopted gender, but -- and
24 so they may be uncomfortable not being able to do that.
25 It may be a stressor in terms of their gradual

1 transition to becoming male, but one of numerous
2 stressors in that process. And so that's what I would
3 say.

4 **Q What is your specific basis for your opinion**
5 **that allowing a transgender student to use a restroom or**
6 **a locker room corresponding with their gender identity**
7 **will likely cause short-term embarrassment and harm for**
8 **children and "potential future harm"?**

9 A Well, I think the basis was seeing, and again,
10 I'm not talking about someone being in a stall. If they
11 didn't see anything and an individual quietly went into
12 a stall and just slipped out that's different than
13 seeing an individual at a urinal and if a young girl saw
14 that, it may be distressing to her.

15 **Q What --**

16 A But in this case it would be a young -- a
17 young boy who.

18 **Q And what are you basing that opinion on?**

19 A Just to make sure what we're talking about,
20 could you restate the opinion that you read?

21 **Q Yeah. You had an opinion that allowing**
22 **transgender students to, as far as I understood, this is**
23 **your opinion, allowing transgender student to use the**
24 **restroom or locker room corresponding with their gender**
25 **identity will likely cause short-term embarrassment and**

1 harm for children and "potential future harm." I want
2 to know what specific studies or research --

3 A No. This is a --

4 Q -- are you relying on?

5 A This is a clinical statement that, again, the
6 research hasn't been done on comparing kids who are
7 going to the restroom or not, interviewing kids who have
8 seen transgender kids in the restroom or not. I mean,
9 that -- the questions you are asking need -- would
10 benefit from empirical data. But as a clinician, that
11 opinion is based on kids being exposed to certain
12 observations, and a key word there is locker room. So
13 it lumps several concepts together. Seeing the opposite
14 genetic sex in a shower room or undressed is different
15 than observing the opposite sex slip into a stall and
16 slip out of that. There's a range of exposures.
17 Obviously, one slipping into a stall and out may not
18 have any effect of any great deal, certainly long- term.
19 On the other hand, because children are not cut from a
20 cookie cutter mold, and by that I mean some children
21 have been abused, some have been exposed to parent's
22 sexual activity. Some -- all kinds of things. Seeing
23 the opposite sex person either in a state of elimination
24 or partial clothed would be stressful. But and of
25 course we're mixing several things. If a genetic male

1 is in the -- in their own assigned bathroom and a
2 genetic female comes into that, they may see a male in
3 the urinal. If -- if a genetic female is urinating and
4 in a stall, a genetic male coming in may not see it. So
5 they're different combinations.

6 Q So your concern is someone seeing --

7 A I think that was --

8 Q -- a body part, right?

9 A Pretty much. That's the thing that would
10 trigger most distressing things for children. This is
11 not -- regarding that statement, there wasn't directly
12 related to the statement of Drew Adams or the case of
13 Drew Adams. It was a general statement.

14 Q Okay. Now, the people in the high school,
15 they're not children, right?

16 A They're not -- well, they're children but we
17 call them adolescents. Yeah.

18 Q What -- you used the word children in your
19 report and adolescents, so can you give me what age
20 range you're referring to when you use the word
21 children?

22 A We generally refer to children 12 and under,
23 and adolescents to teen years, 13 to 18. That's a rough
24 -- rough guideline. And, of course, Drew would be an
25 adolescent.

1 Q And your opinions regarding, you know, you
2 seeing someone partially clothed or in the state of
3 elimination that that could possibly be distressing to
4 someone. That's based on your -- that -- it sounded
5 like that's based on your experience as a clinician.
6 There's no study or research on this, right?

7 A Well, I wouldn't go so far as to say that. I
8 think the issue of what we don't have much research on
9 is kids going to bathrooms that are not their genetic
10 natal sex. But kids being exposed to bodies of the
11 opposite sex, nudity of different kinds of things, it
12 clearly -- there is research on that. I can't quote
13 exactly a study that might be relevant here, but the
14 general child development term is that some modesty
15 respect as a child is developing secondary sex
16 characteristics is kind of a standard approach to child
17 development. Now, the problem is clinically what we
18 face is there's no, as I said earlier, no one size.
19 Children have multiple different experiences in terms of
20 sexuality and, therefore, each experience could be
21 experienced to someone differently. Some child may not
22 be bothered at all. Another might be terrified --

23 Q Okay.

24 A -- based on their experience. And in a public
25 institution and an institution of many, I guess we

1 talked earlier, conflicting needs, that's the problem.
2 There are multiply -- multiple different needs of kids
3 there in schools.

4 **Q Okay. And you don't think that the**
5 **adolescents, for instance, at Drew's school should cope**
6 **as your recommending Drew copes with having -- for**
7 **instance, with having a transgender person in the**
8 **restroom.**

9 **A** Oh, no. I think -- I think they should. If -
10 - if -- if that took place. I think that they would be
11 forced to cope either way just as I suggested Drew
12 should. My point with Drew is that choices have
13 consequences, and he made an enormous choice, which
14 changes his entire human experience, goes against
15 biology, and that -- that has major implications. And
16 to make that choice and then expect that everyone else
17 in the school, or a majority of the school or a good
18 number, don't have issues, or problems, or concerns, is
19 a little bit na

20 **Q Well, what -- you said a majority, a good**
21 **number of people have -- don't have concerns. Are you**
22 **aware of a single person at Drew's high school who**
23 **expressed a concern with him being --**

24 **A** I'm not aware of that. I'm just saying if you
25 have a school of whatever, 2,000 kids, and they're --

1 based on my experience in other schools, there are some
2 parents that have concerns about this.

3 Q But not at Drew's school that you're aware of,
4 right?

5 A I'm not aware of any. No.

6 Q Okay. And you said a major life choice.
7 You're referring to transitioning gender, correct?

8 A Right. To be born female and then say I will
9 be a male.

10 Q Okay. Well --

11 A Or I am a male, or however one phrases that
12 situation.

13 Q You said -- so you -- in your opinion, being
14 transgender goes against biology?

15 MR. KOSTELNIK: Form.

16 Q What do you mean by that?

17 A Well, we're born male and female, XX, XY is
18 the genetic component of that in that it distinguishes
19 two members, two types of the human race, always has,
20 and then to then state that I feel male, in this case,
21 and therefore I am male, that goes against the facts of
22 biology.

23 Q Well, Drew Adams didn't just say "I feel
24 male," right?

25 A Right. He is now said "I am male."

1 **Q Right. And that's part of how people identify**
2 **with their gender identity, right?**

3 A Right. That's how they feel, and that's the
4 point, as I mentioned in my report, the difference
5 between a fact and a feeling. Drew ignores the facts
6 and then goes on his feelings, and that's what this case
7 is in some ways about.

8 **Q Do you agree there's different components of**
9 **biology? For instance, there's people with disorders of**
10 **sex development. They are not just -- they are not**
11 **assigned male or female at birth, right?**

12 MR. KOSTELNIK: Form.

13 A No. The human condition involves normal
14 physiological physical development, and involves many
15 disorders, and diseases, and problems, and that's true
16 with most organ systems and that's true with endocrine
17 systems and disorders of sex development, like
18 congenital adrenal hyperplasia, and so forth. My point,
19 this is a crucial point, I'm sure we'll come back to it
20 many times, but the fact of biology is being replaced by
21 the feeling of gender, and that's a massive shift and
22 it's going on in our culture, and there's a lot of
23 unclear thinking about it.

24 **Q And you're in the minority on the standard of**
25 **care for transgender healthcare, right?**

1 MR. KOSTELNIK: Form.

2 A Well, I go along with a number of things of
3 the standards of care. I think the main one that I very
4 much go along with is the notion of exploration of
5 psychological life in preparation for transition that,
6 in various standards of care makes clear. Now, the
7 thing I might have issue with is that the focus is all
8 one way in that it's preparing for a physical biological
9 hormonal surgical transition. That's the focus of that.
10 If one is more open in your exploration of psychological
11 life, I totally support that as a part of standard of
12 care. And it actually true, whether it's the American
13 Academy of Child and Adolescent Psychiatry, American
14 Psychological Association of World Profession Associates
15 and Transgender Health Professionals all have a
16 variation of that, of caution, exploration, as one moves
17 toward transition if transition does take place.

18 Q Who has a focus? Who's -- you said there was
19 just a focus on transition. Who are you referring to?

20 MR. KOSTELNIK: Form.

21 A In the regulations I've read and the -- it's
22 most specific in the professional -- as you would
23 predict, a Professional Association of Transgender
24 Health Professionals, that there are stages of
25 transitioning encourage psychological evaluation at the

1 second or third stage. I can't remember. And my sense
2 in reading that was that it's preparation for the final
3 stage of assigning a new sex. In more general terms,
4 psychological exploration is exploring the individual's
5 whole emotional psychological life.

6 **Q So you disagree with WPATH guidelines on that?**

7 A I'm not sure I disagree with it. I think I
8 have a different perspective on them.

9 **Q Okay.**

10 A And can I -- can I -- this may be out of
11 school but I think this story -- we were talking about
12 guidelines and there's three, or four, or five. There's
13 also the Endocrine Society's guidelines that it's very
14 important to realize that their guidelines and they
15 touch an enormous number of areas. So I remember a very
16 well-known politician who said once "Look, if you agree
17 with 85 percent of what I say, vote for me. If you
18 agree with 100 percent of what I say, see a
19 psychiatrist." My point is these guidelines, for you to
20 ask do I agree with them, or not, I mean, I agree with
21 a good bit of them. But at certain points, I would
22 divert from them. It depends on what the specific issue
23 in the guidelines is.

24 **Q You mentioned your opinion that some students**
25 **may be harmed possibly by having as you describe it, a**

1 natal -- a person of a different sex assigned at birth
2 in the restroom. But are those students going to be
3 irreparably harmed if they see --

4 MR. KOSTELNIK: Form.

5 Q -- if they see a transgender student in the
6 restroom with them?

7 MR. KOSTELNIK: Form.

8 A I didn't use that word, and irreparably is a
9 very strong word, and I object to it being used to Drew
10 and I'll object to it being used to a child. I can't
11 say. I will reaffirm that you don't know where --
12 because of the range of children, particularly know the
13 incidence of sexual abuse, neglect, these things are
14 skyrocketing. Children often don't have parents,
15 families are fragmented. And so every individual child
16 may not be psychologically sturdy when they walk into
17 that restroom. A sturdy one probably like water rolling
18 off a duck's back. It wouldn't be a problem, but some
19 may be affected very significantly. Visual image -- a
20 visual image, something.

21 Q But there's no evidence of anyone being
22 harmed, irreparably or not, at Drew's school, correct?

23 A There is no evidence that I've seen.

24 Q What is your basis for your opinion that Drew
25 is not irreparably harmed by being denied the restroom

1 **corresponding with his gender identity?**

2 A He continues to go to school. He continues to
3 function. He continues to be involved with special
4 projects of a community nature, of an advocacy nature,
5 and youth who are harmed, those who've been abused or
6 traumatized present with a certain sense of
7 vulnerability and fragility, and in laymen's terms, it
8 would be a lack of self confidence. I base some of
9 that, in large part, of just seeing the videos that he's
10 posted, and you know there's a jocular ease with which
11 he presents himself. It's almost as if he's on stage.

12 **Q Okay. So again, you're using only the videos?**

13 A Well, that's the data. I haven't, as you've
14 said earlier, I haven't interviewed him. I haven't
15 talked to him. But everything about the case, to use the
16 word irreparable harm, nothing feels like irreparable
17 harm, here. Difficult, maybe, but harmful,
18 questionably.

19 **Q And it's just your feeling that you get?**

20 A Well, no. It's just the context of
21 development and the situations that the patients I've
22 talked to and the people that I've -- I'm not saying he
23 never has said that, but to be irreparably harmed, it --
24 it would be difficult to see how he would be irreparably
25 harmed rather than deal with a difficult event.

1 Q And you never evaluated him to see how he
2 could be irreparably --

3 A No. I have not.

4 Q -- how he could be irreparably harmed,
5 correct?

6 A Correct. Yeah. I've seen no evidence for
7 that, and if there is evidence there, I'd like to see
8 it, because it's hard to believe it could occur.
9 Difficult but not irreparable harm.

10 Q Okay. When transgender adolescents are
11 provided with hormone treatments, they develop secondary
12 sex characteristics with their -- to match their gender
13 identity, correct?

14 A Yes.

15 Q Okay. And there is gender clinics across the
16 country that provide gender just work adolescents with
17 hormonal treatments, right?

18 MR. KOSTELNIK: Form.

19 A Yes. They've skyrocketed in the last ten
20 years. That's right.

21 Q Okay. And they are following WPATH guidelines
22 and Endocrine Society guidelines, correct?

23 MR. KOSTELNIK: Form.

24 A I believe they are most part. The Endocrine
25 Society just changed them three weeks ago. This is a

1 shifting area, but yeah.

2 Q Okay. And so in many public -- or many
3 schools across the country, would you agree that there
4 are transgender high school students who have physically
5 transitioned?

6 MR. KOSTELNIK: Form.

7 A Oh, they're increasing numbers. Yes.

8 Q So my question for you is which locker room
9 should a student use if that student is transgender girl
10 who has been treated with puberty blockers and cross sex
11 hormones, and thus has breasts, curvy figure, and
12 appears to be a girl in all ways? Should she use the
13 boy's locker room or the girl's locker room?

14 A So you're talking about a genetic male who now
15 has female characteristics?

16 Q Well, I would not describe it in those words,
17 but I would say a transgender girl, the way I said it.

18 MR. KOSTELNIK: Form.

19 A Okay. Yeah. And but has these female
20 characteristics, the transgender girl?

21 Q Yes.

22 A Yeah. Okay. And so the question is should
23 she be in a locker room --

24 Q Should she go to the boy's locker room or the
25 girl's locker room, if her body and the way she presents

1 **is a girl?**

2 A The closer it becomes to being
3 indistinguishable, she could then be part of a girl's
4 locker room, and with the legal parts as an adult,
5 that's where she's headed. This is a transitional
6 disorder. This is a movement from one profoundly kind
7 of rooted in biology condition to a newly created one,
8 and this takes time, it takes judgments. So
9 theoretically, I would agree at some point she looks
10 like a girl, acts like a girl, talks like a girl, people
11 refer her to like a girl, she's comfortable in being a
12 girl, and if somebody can pull that off by the time
13 they're 15 or whatever the time is, sure.

14 **Q She should go to the girl's locker room,**
15 **right?**

16 A Right. But that's -- that's an end of one and
17 that situation is highly -- hasn't developed that much,
18 because this thing, this movement, this change has only
19 been with us barely ten years, and there's so many
20 unsettled questions we don't know, and so...

21 **Q You said closer to indistinguishable. What**
22 **did you mean by that?**

23 A As much as medical science can do, the girl
24 would be recreated in the image -- or, again, I get
25 confused, forgive me. So this would be someone who's

1 become a female with all the characteristics -- physical
2 characteristics of a female that if medical science has
3 made her a perfect replica, so to speak, yeah, then it
4 would be hard to say well, you could. It's very
5 important as a medical scientist, someone who goes
6 through that procedure is still a male but looks like a
7 female and feels like a female and identifies as a
8 female, but they're biologically still a male.

9 **Q That's your opinion?**

10 A That's my opinion.

11 **Q You mentioned a transitional disorder. Does**
12 **that mean being transgender?**

13 A No. The nature of this disorder is one of
14 moving from something to something else, that's what I
15 meant. Transitional. They're on the -- on the way to
16 becoming, and in the example that you just mentioned,
17 they are becoming and, perhaps, the way you painted
18 that, they have become a fully female in gender and in
19 appearance.

20 **Q You said -- but I still don't understand what**
21 **you mean. You said nature of this disorder again. What**
22 **disorder?**

23 A The gender dysphoria.

24 **Q Okay. And you said this thing, this movement,**
25 **and I didn't know what you were referring to. You said**

1 **this thing, this movement is changing.**

2 A Well, the absolute -- and I'm not sure of
3 exact data, because I'm not sure they're there, but in
4 my own clinic, in my own practice, these kids, the
5 numbers of them are skyrocketing. And I think it will
6 only increase. And so my point then is this is a
7 sociocultural fueled movement of sorts. It -- it's not
8 -- it has no foundation in biology in that sense. It is
9 fueled by sources that have a movement-like feel to
10 them, and the exact end of it is hard, but it is in my
11 own clinic, to give you a sense of it, my career is 40
12 years old, 30 to -- 20 to 30 years ago, we didn't see
13 them. Saw a few maybe ten to 15 years ago, and these
14 endocrine clinics that you refer to, the hormone change
15 will just were imported into this country from the
16 Netherlands ten years ago, and now have skyrocketed.
17 And the number of cases have skyrocketed and in my own
18 clinic in the last two years, probably tripled the
19 number of cases. So that's -- as a physician
20 epidemiologist perspective, you have to say what is
21 going on. What is this? So I just choose the word
22 movement, but I think you get my point.

23 Q So your opinion is that because there is a
24 higher prevalence of transgender youth, that the reason
25 -- that the reason for that is that there -- it's fueled

1 **by some sociocultural --**

2 A Well, no. That's just a description of fact.
3 It's not -- nothing's changed in the biology of kids, in
4 medicine, and what we know. So there's only one other
5 explanation. It's psychosocial forces fueling, but we
6 don't know. And that's a key point in my opinion is
7 that the science is unsettled. We don't know many
8 things. We don't know what this all means at one level.

9 **Q Could it be that there's more acceptance and**
10 **greater gender affirming treatment for people and that's**
11 **why people are identifying more with their true gender?**

12 A You know, that's an argument, but I think
13 that's creating these kids. I don't think it's
14 identifying stuff that's all there. That would not be
15 my view.

16 **Q And what is that based on?**

17 A Clinical experience doing psychiatry for 40
18 years. We didn't -- just the nature of illnesses and
19 disorders, and how change occurs. That is an argument.
20 People are just coming out from -- if I could use
21 another example from medicine in my own specialty.
22 We've just come from an era where we have massively over
23 diagnosed bipolar disorder in children, and that was
24 always the argument, we've just been missing. Now,
25 they're coming out and 15 years later it's clear that we

1 were just misdiagnosing, over diagnosing, and these kids
2 were never there to begin with. But those are the
3 academic debates, but that's where we are and that's why
4 I say the science is unsettled.

5 **Q Do you think school districts should check**
6 **student's genitals to make sure they're using the**
7 **restroom that matches their sex assigned at birth?**

8 A That seems to be a bit far to me.

9 **Q Well, how do you -- okay, well, strike that.**
10 **But your -- I mean, your opinion if I'm -- is it your**
11 **opinion that students should use restrooms corresponding**
12 **with their external genitalia at birth?**

13 A No. No. And I think the impressive thing
14 about this school district what they've done, they are
15 not forcing Drew to go to any extent to go to a female
16 restroom. He's uncomfortable with that, and they're not
17 -- it shouldn't -- you shouldn't be forced. But because
18 there are so many conflicting forces, different views,
19 he's in transition, having a neutral bathroom that
20 anyone can go to, he's not stigmatized in that sense.

21 **Q Well, he's not in -- do you know if his**
22 **transition is complete? I think you said you don't**
23 **know, right?**

24 A I don't know. I don't know where that's at.
25 It's --

1 Q If a student --

2 A It's in -- go ahead.

3 Q I'm sorry. Do you assume that transgender
4 individuals are more likely than others to sexually
5 harass or assault other students in the restroom?

6 A No.

7 Q Do you assume transgender individuals are more
8 likely to expose themselves than other students in
9 bathrooms or locker rooms?

10 A No. As a general rule, transgender
11 individuals that I've treated and working with right now
12 are very concerned about the gender that they're leaving
13 in that they are not aggressive types of individuals.
14 They tend to be more passive, anxious, withdrawn kind of
15 individuals, withdrawing from certain things. So they
16 are -- to use a prototype of adolescent psychiatry, not
17 -- not an aggressive group of people, and they're not --
18 others are not really at risk for being around them, at
19 risk physically as you were saying, being attacked or
20 brutalized, or...

21 Q Are they at risk for sexual harassment?

22 A You mean them harassing somebody else?

23 Q Yeah. Transgender students in the restroom.

24 A Them being harassed or them harassing?

25 Q Them harassing cisgender students.

1 A My experience is that they -- it's usually the
2 reverse. You know, they're the recipients of the
3 harassment, but --

4 **Q Transgender students are usually the**
5 **recipients of harassment?**

6 A Right. Yeah. Yeah.

7 **Q Yeah.**

8 A There may be some who would harass others and
9 if the - - the movement that those consider, and we've
10 seen that in other situations where minorities then
11 assume power as they grow, and grow, and grow in
12 numbers, they might harass others, but, right now,
13 there's no evidence that transgenders harass any kids.

14 **Q Are you -- well, okay. That's good. Thanks.**
15 **Now, I notice you added something in your rebuttal**
16 **report on this topic, and I can show it to you if you**
17 **want, but it said troubled girls from troubled families**
18 **may appreciate uninvited looks placing undue and**
19 **unneeded peer pressure on other females not desiring**
20 **such visual inspection.**

21 A Right.

22 **Q So was this opinion that some "troubled girls"**
23 **may appreciate a transgender girl in the restroom giving**
24 **them "uninvited looks?"**

25 MR. KOSTELNIK: Form.

1 A No. It didn't refer to transgender. The idea
2 there would be if there's a transgender male in the
3 restroom, the troubled girl may appreciate being
4 inspected partially disrobed, and so forth by a male.
5 So the issue there is troubled girls -- we've known this
6 for a generation. Dysfunctional families, absent
7 fathers, mothers who are poor role models are at great
8 risk for premature sexual activity, premature pregnancy,
9 various kinds of sexual activities that are not healthy
10 for their future adjustment, and those kind of kids,
11 yeah, become seductive, and get involved with boys in
12 unhelpful ways. That was, I think, the general idea
13 there. And it makes the general point, underscores that
14 I've made already is that if you mix lots of different
15 types of kids in a public kind of setting that is you
16 don't know quite who's in there, in the restroom.

17 **Q But your example was presuming that there**
18 **would be someone who was transgender in the restroom,**
19 **right?**

20 A Yeah. Someone who -- let me think of the
21 combinations here. So if you have a young girl who's
22 being observed -- being observed by females is not the
23 issue, being observed by males would be the issue. And
24 then in this context of our discussion, that would be a
25 transgender male.

1 Q Okay.

2 A So I guess what I'm saying, the transgender
3 male isn't going to assault this young girl, isn't --
4 based on what we know of these kids, but just by virtue
5 of being there and looking at her partially disrobed, it
6 creates issues for the girl. And then other girls, that
7 final statement I made there, are then in a competitive
8 thing where, you know, then they --

9 Q So you assume in that opinion that the
10 transgender person would be sexually leering at the
11 "troubled girls"?

12 A No. Just looking. I didn't say leering, but
13 just the fact of being there observing, that kind of
14 thing.

15 Q And why would a transgender male be in the
16 girl's restroom?

17 A Well, I think -- I don't know how I used that
18 example, but in terms of -- I thought that's what this
19 case was about, although -- yeah. I don't know --

20 Q Okay.

21 A -- why he would be there except he would be
22 allowed to -- to be there.

23 Q Have you been given any evidence to suggest
24 that Drew Adams gave any person uninvited looks in a
25 restroom?

1 A No.

2 Q Or in a locker room?

3 A No.

4 Q Can you -- are you aware of any instance where
5 a cisgender person poses as a transgender person in
6 order to use a particular sex designated facility?

7 A I'm not aware of that. No.

8 Q Can you identify a single instance where a
9 transgender individual has used a restroom associated
10 with his or her gender identity in order to engage in
11 inappropriate behavior in the restroom?

12 A I have not seen any incident in my clinical
13 work.

14 Q Okay. Now, you mentioned that in your
15 experience, you've seen that transgender students are
16 often the ones being harassed at school; is that right?

17 A That's correct.

18 Q Okay. Have you worked with any school
19 districts to help prevent prejudice and harassment
20 towards transgender students?

21 A Not in an educative sense. I consult with
22 residential treatment centers. I work with their staff
23 in trying to help them understand this -- this issue.
24 But I think stigma and harassment is a problem for this
25 patient population. Yeah.

1 Q Which residential center do you work with?

2 A One here in Kentucky, the one I'm working with
3 right now is called Buckhorn Treatment Center.

4 Q Buckhorn Treatment Center?

5 A Right. It's a residential treatment center
6 for girls. It may not be on my CV. I've done that over
7 my whole career in different centers. It's often part
8 of an academic CV, but --

9 Q Okay.

10 MR. KOSTELNIK: Do you mind if we take a break?

11 MS. NARDECCHIA: Sure.

12 MR. KOSTELNIK: Okay.

13 VIDEOGRAPHER: It is 10:44, and we are off the
14 record.

15 (OFF THE RECORD)

16 VIDEOGRAPHER: It is 10:55, and we are back on
17 the record.

18 BY MS. NARDECCHIA:

19 Q Dr. Josephson, are you offering an opinion
20 that cisgender students at Drew's school will suffer a
21 violation of their "privacy rights" if transgender
22 students are permitted to use the restrooms
23 corresponding with their gender identity?

24 A Yeah. I think some kids would. I'm not sure
25 they would all feel the same way, but, you know.

1 Q Okay. And just to be clear, are you aware of
2 any specific students who --

3 A I'm not.

4 Q All right. Just let me finish my question.

5 A Sorry.

6 Q Are you aware of any specific students who
7 felt that their privacy rights were violated by Drew
8 using the restroom?

9 A No.

10 Q Are you aware of any instances generally of
11 any student saying that their privacy rights were
12 violated by a transgender student using the restroom?

13 A I have been in other situations talking to
14 clinicians, other legal cases. They often don't use the
15 word privacy rights, but uncomfortable, I didn't like
16 seeing this. They tell their parents. The parents then
17 express concerns to the school, that kind of -- I'm
18 aware of that. But not in this particular case.

19 Q Okay. And you're not an expert on privacy
20 rights, correct?

21 A I'm not. I'm a doctor.

22 Q Do you think -- well, what research or studies
23 have you analyzed that evaluate the impact of cisgender
24 -- on cisgender students when transgender students use
25 the restrooms corresponding with their gender identity?

1 A Those studies are in their infancy. I'm sure
2 there are some developing. We just don't know. The
3 science is unsettled.

4 **Q Which studies are in their infancy?**

5 A Well, you would have to interview kids who
6 were either exposed or weren't exposed. Which gender
7 combinations were they exposed to or not, and develop
8 comparison groups not only cisgender but other gender
9 orientations and so forth, and then have the right kind
10 of instrument to measure what kind of responses. To do
11 a real good study, then you would follow up further. To
12 answer your question, did it have any lasting impact,
13 and those are just extraordinarily expensive and I'm
14 just -- I'm not aware of any being done right now, but
15 there may be.

16 **Q But you haven't done any, right?**

17 A No. No.

18 **Q Okay.**

19 A And I'm not going to, either.

20 **Q Okay. In your hypothetical situation of**
21 **possibly some kids could feel that their privacy rights**
22 **were violated by a transgender student using the**
23 **restroom, couldn't those some students use the gender**
24 **neutral restroom if they wanted to?**

25 A Yes. They could. Yeah. And that's the

1 beauty of the gender neutral restroom. I mean, it's
2 kind of allows for just a compromise intermediate
3 position. Yeah. They could. Sure. They could.

4 **Q And can you tell me your specific basis for**
5 **your opinion that denying Drew the ability to use the**
6 **restroom that matches his gender identity will not harm**
7 **him?**

8 MR. KOSTELNIK: Form.

9 A Well, to stick with the theme here. The
10 studies haven't been done. It is time limited. He will
11 graduate soon. If he can look more and more like a male
12 and present more and more like a male, and have the
13 legal credentials, he will move on with his life. And -
14 - and then to stick with my previous point, he will have
15 recovered or gone through a difficult experience in
16 adolescence not unlike numerous other adolescents with
17 other issues.

18 **Q Well, the --**

19 A The basis is adolescent development, child
20 development, what is serious and what is not serious,
21 what's difficult and what's not, and in my experience,
22 with what we call developmental psychopathology, I know
23 the difference.

24 **Q Okay. But there is medical literature out**
25 **there saying that it is a very serious harm to**

1 **transgender students to not affirm them in their gender**
2 **identity, correct?**

3 A Yeah. I think they need to be affirmed, but
4 to say there's a serious harm, again, those studies
5 haven't been done. The main theme here is the science is
6 unsettled in so much of this. No. Interpersonally,
7 people should -- everyone should experience in our
8 country human rights and support for that. But to say
9 they would be harmed, that's -- that's a significant
10 statement for a physician to make.

11 **Q So you don't think there's any medical support**
12 **in peer-reviewed studies and literature that that is**
13 **harmful to transgender students to not affirm their**
14 **identity?**

15 A There is emerging support, and then there's
16 also questions about these studies and the methodology
17 in the number of them, so forth. So and --

18 **Q Is there any medical literature that concludes**
19 **that, to support your position, that denying them the**
20 **ability to use the restroom will not harm them,**
21 **transgender students, I mean?**

22 A See, again, we don't know. It's too early.
23 The way studies are typically done in medicine, when
24 you're trying something dramatically new, and this
25 obviously fits that category. You do pilot studies.

1 You do small groups. You demonstrate that it is useful,
2 helpful, then you magnify that and create larger
3 studies, larger groups to then verify this new change
4 has been helpful rather than to do it, which is what is
5 being proposed, and then after the fact seeing if it's
6 worked. I'm worried that there are studies out here and
7 there is a -- go ahead.

8 MS. NARDECCHIA: I'll move to strike as
9 nonresponsive.

10 Q So are you -- yes or no, are you aware of any
11 studies that support your opinion that denying
12 transgender students the ability to use the restroom
13 that matches their gender identity will not harm them?

14 MR. KOSTELNIK: Form.

15 A I'm not aware of any studies.

16 Q Thank you.

17 A And in your example of, you know, some kids
18 could use the gender-neutral restroom, that would be
19 their choice, right? They could use the restroom that
20 corresponds with their gender identity or the gender
21 neutral restroom if they didn't want to be in the
22 restroom with a transgender student?

23 MR. KOSTELNIK: Form.

24 A That's my understanding. I'm sorry. Yeah.
25 That's my understanding that the children in the school

1 district in question can do that.

2 Q But Drew does not have a choice, right? He
3 cannot use the boy's restroom.

4 MR. KOSTELNIK: Form.

5 A That's my understanding.

6 Q Now, you said Drew can just move on when he's
7 an adult, but that doesn't negate the fact that he is
8 currently suffering harm as a result of being denied the
9 ability to use the boy's restroom, right? Even if he
10 can later move on, that doesn't mean that he's not
11 suffering harm now, right?

12 MR. KOSTELNIK: Form.

13 A Again, I do not use the word suffering harm.
14 These are strong statements. Suffering and harm are
15 strong statements for a physician.

16 Q Okay. Do you agree that there's any level of
17 harm that Drew has suffered as a result of being denied
18 the boy's restroom?

19 A No. It's been difficult for him.

20 Q But no harm, whatsoever?

21 A No.

22 Q And you said once he had his male credentials,
23 he could begin using the boy's restroom. Do you know if
24 he currently has his male credentials?

25 MR. KOSTELNIK: Form.

1 A Well, we talked earlier. I guess he may have
2 his birth certificate changed, and that's what I meant
3 by credentials. The legal documentation. I don't know
4 if anything else besides birth certificate and driver's
5 license but, yeah, so that's a -- that's my point
6 earlier. A transition, you move toward that. If that's
7 his goal, he will be supported in that, society will be
8 supportive in that, and he -- if he's just patient,
9 that's going to happen.

10 Q **If he's patient, what will happen? The school**
11 **will let him use the boy's restroom?**

12 A It may not be while he's in high school, but
13 he'll pretty quickly go to college and go to other
14 public facilities, and if he looks like a male, that's
15 where he'll go. No one's going to inspect genitals.

16 Q **Do you think he looks like a male?**

17 A I think he's -- he's well on his way. He
18 looks like an effeminate young boy right now, but he --
19 by his own admission, would like to have more facial
20 hair and so forth.

21 Q **So your opinion is that he's an effeminate**
22 **looking male because he doesn't have facial hair?**

23 MR. KOSTELNIK: Form.

24 A Well, that's part of it. Yeah.

25 Q **What other part?**

1 A His demeanor, his facial characteristics, but
2 he's on his way to becoming a male and, depending on the
3 hormones and the work, we'll see what happens.

4 Q Do you think there's anything wrong with being
5 an effeminate looking man?

6 A Of course not.

7 Q I mean, it's fine for boys and men to look
8 effeminate, right?

9 A That was a descriptive statement. It's not
10 any statement of judgment. I mean, it's -- but if he
11 would be shown these videos, these pictures to 100
12 people, 80 of them would say he's effeminate-looking.
13 That's not a judgment. It's --

14 Q But an effeminate looking boy, right?

15 A Correct. Yeah.

16 Q Okay. In your experience -- well, strike
17 that. In your opinion, is the school district
18 interfering with Drew's medical treatment by preventing
19 him from fully socially transitioning by using the
20 restroom corresponding to his gender identity?

21 MR. KOSTELNIK: Form.

22 A You know, it's a challenge in his transition,
23 but they're not preventing it and, as I mentioned
24 earlier, multiple treatment decisions in medicine are
25 affected by intervening or contravening variables.

1 **Q You said they're not preventing it. What did**
2 **you mean?**

3 A In other words, going -- going -- going to the
4 restroom consistent with his gender and not being able
5 to do that is, as I said, difficult. It's a challenge
6 for him. One I think he will, with the appropriate
7 coping facilities, master. He'll be able to do that.
8 But it's not like a treatment plan is all or none. Most
9 treatment plans in medicine involve like five steps.

10 **Q Do you know if full social transition is part**
11 **of Drew's medical plan?**

12 A (Coughs) excuse me. That would be the plan,
13 but even full social transition, that's taking a very
14 broad, somewhat vague construct of social adaptation
15 that had multiple parts to it, and, yes, going to the
16 bathroom of his choice if he's not able to and has to go
17 to a neutral bathroom is a stress, I would suggest a
18 difficulty, but in the process of human development,
19 adolescent development, there are numerous things that
20 kids run into. And -- and, in fact, in Drew's life,
21 there will be stresses as there are in everyone's life
22 that are probably much more serious than this one.

23 **Q The expert report that you submitted in this**
24 **case, did it contain all of the opinions you intend to**
25 **provide in this matter?**

1 A Pretty much. I will be reviewing the
2 depositions that we discussed earlier and certain
3 materials that I may not have gotten to. There may be
4 some studies. There are a couple that have come out
5 this week I'll be looking at. But for the most part, if
6 the trial is pretty soon, this is what I'll be saying.
7 Yeah.

8 **Q Which studies are you going to review?**

9 A There was one study under review of research
10 in transgender, I think it was the "Journal of Child
11 Psychology Psychiatry." I don't have the authors just
12 off the top of my head. And there was one other that I
13 noted I have to look up.

14 **Q Did your expert -- (clears throat) excuse me.**
15 **Did your expert report contain all the facts or data you**
16 **considered in forming your opinions?**

17 A It wouldn't be all the facts or data. In
18 other words, there were in my bibliography I have a
19 number of articles. I just referenced a few. The
20 report had its limitations so I can't say there is
21 everything there, but -- but the thrust of what I'm
22 saying today and what I will say is there. Yes.

23 **Q Were there any facts or data you considered in**
24 **forming your opinions that are not contained within your**
25 **report or your bibliography?**

1 A Not that I can say right now. I think the --
2 no. I'd say no.

3 Q Okay. I think you testified earlier before
4 break that you had a different CV; is that right? Other
5 than the one you submitted with your report?

6 A No. I made the comment that in my clinical
7 work, part of the clinical assignment in our division is
8 to consult to various residential treatment centers. So
9 it's part of my regular job. I didn't pull that out as
10 a special -- I don't have a contract with this treatment
11 center. In our division of child psychiatry, we do a
12 whole number of things. So it's --

13 Q Okay.

14 A I guess what I was trying to say, if you look
15 for the -- you asked the name of it, the Buckhorn
16 Residential Treatment Center, you won't see it in my CV.

17 Q Okay. I understand. And so your --

18 A But there's only one CV.

19 Q The work with the Buckhorn Treatment -- or
20 residential facility is part of your work with the
21 Bingham Clinic?

22 A At the University of Louisville. Yeah.

23 Q Okay.

24 A Yeah.

25 Q Have you ever been qualified in any court as

1 **an expert in issues relating to gender identity?**

2 A Over the last maybe year-and-a-half I've
3 prepared a number of reports, and the way the legal
4 process works, I've been close to depositions several
5 times. They've been cancelled, this kind of thing, but
6 this is the first time. There have been four or five
7 other cases that I responded to lawyers' request for
8 psychiatric information, prepared a report. I submitted
9 those, but no other cases beside this one where I've
10 been sitting with opposing counsel.

11 Q But -- so just so I'm clear, no judge has
12 found you qualified to be an expert in issues regarding
13 gender identity yet, correct?

14 A That's correct. That's correct.

15 Q And the four cases that you've submitted
16 expert reports for within the last year-and-a-half that
17 would be Hylund, Carcano, the District 211 case, and
18 Boyertown; is that right?

19 A What was the second one?

20 Q Hylund, Carcano. Carcano's a North Carolina
21 case.

22 A Oh, North Carolina. Yeah.

23 Q District 211 is the privacy -- the group for
24 privacy rights, and Boyertown. Are those the four?

25 A I'm still struggling with District 211.

1 Q Okay.

2 A Is that the Illinois, was it the Illinois --

3 Q Illinois.

4 A Illinois. Yeah. I go by state, so --

5 Q Okay.

6 A -- those are the ones, I believe where I've
7 submitted reports. Yes.

8 Q Okay. And in any of those four cases, did you
9 personally evaluate or treat any of the individual
10 transgender people involved in those cases?

11 A No. And, in fact, the -- what was your second
12 one? Was that Ohio?

13 Q I actually don't know the state. I can -- I
14 have the documents in here.

15 A Well, no. The reason I asked is that I was
16 asked to do in Ohio and that's when we delved into it
17 further regarding the licensure issue, and these states
18 didn't allow it. I was asked to look at a case in
19 Wisconsin, but similarly I would need to have a license
20 to examine an individual. But the answer to your
21 question, so I haven't examined any kids in these cases.

22 Q And those four cases regarding transgender
23 individuals, your reports were all submitted on behalf
24 of the defendants in those cases, right? The school
25 districts?

1 A The one was kind of complicated. The
2 defendant became a plaintiff, or something. I'm trying
3 to remember. But that was true in the other instances.
4 The -- I think the Ohio case was different.

5 Q Well, in other words, none of your expert
6 reports have been on the side of the transgender people,
7 correct?

8 A That's correct.

9 Q Okay. They've all been in support of the
10 schools?

11 A Right. Or I think parents were involved with
12 -- with the Boyertown case, and may have been involved
13 in the Ohio case, but not -- not for transgenders, yeah,
14 for the defendants.

15 Q Uh-huh. For the side that wanted to prohibit
16 transgender people from using restrooms that
17 corresponded with their gender identity; is that true?

18 A Right.

19 Q Yeah. And you were not found qualified by any
20 judge in any of those cases as an expert, correct?

21 A Never got that far. Yeah.

22 Q Okay. Never -- strike that. What was the
23 first of those cases? Was it the Carcano case, the
24 North Carolina one?

25 A I think so.

1 Q And when you were -- when you were retained as
2 an expert witness in that case, there were other --
3 well, there were psychiatrists that specialized in
4 treating gender dysphoria in children and adolescents at
5 that time, right?

6 A Yes.

7 MR. KOSTELNIK: Form.

8 Q And you were, at that point, not one of them,
9 right?

10 A Not one of them meaning what group?

11 Q You were not one of the psychiatrists who
12 specialized in treating gender dysphoria?

13 A I've not presented myself that way in my
14 career. That's correct.

15 Q And you currently do not present yourself as
16 someone who specializes in treating gender dysphoria,
17 right?

18 A That's correct.

19 Q Or treating LGBT patients, correct?

20 A I've treated many LGBT patients. So and to
21 say you're specialized in it, I -- that's -- that's a
22 little bit of a misnomer. I mean, when you're trained
23 and have the career that -- that I've had as child and
24 adolescent psychiatrist, your -- your career is really
25 specializing in multiple different areas of serious

1 disturbance with kids. Whether it's substance abuse,
2 eating disorders, transgender, but I don't market myself
3 where I identify myself that way.

4 **Q Okay. But there are some psychologists and**
5 **psychiatrists who do market themselves?**

6 A Absolutely, there are.

7 **Q Yeah. For instance, at Bingham Clinic, Dr.**
8 **Christine Brady is one of them?**

9 A She is -- begun to do that. She does a lot of
10 other things for us, but yeah.

11 **Q Uh-huh. Anyone else at the Bingham Clinic who**
12 **identifies themselves as someone who treats LGBT**
13 **patients?**

14 A No. No one -- no one else. Christine would
15 be the one. But we have many very talented people who
16 treat these patients. Our outpatient director whose
17 name is Christopher Peters, he is increasingly seeing
18 these patients. I get referrals in my role of directing
19 clinic from a lot of professional folks, and I recently
20 referred a case to Chris that needed treatment, and he's
21 really a skilled child psychiatrist, and so -- but
22 nobody -- but he doesn't -- even he would not identify
23 himself as a transgender specialist therapist. I think
24 Dr. Brady wants to be seen that way, and will be
25 developing her career in that way.

1 **Q But you don't see her as someone who**
2 **specializes in treatment of transgender patients?**

3 A Oh, and I think she would say she would. She
4 also specializes and does work with cancer patients, and
5 yeah. And what's evolving with, as I mentioned, with
6 the growth of this disorder and issue. We will be
7 developing this further. In my faculty meetings at the
8 present time, we're looking at how we can organize
9 services better, and communicate better with the
10 department of endocrinology. So it's -- it's evolving.
11 But -- but in terms of my role, and at this point in my
12 career, I am not identifying that as something that I'm
13 a specialist in.

14 **Q Have you ever been qualified by any court as**
15 **an expert in any issue pertaining to transgender people?**

16 A No.

17 MR. KOSTELNIK: Form.

18 **Q Have you ever been qualified in any court as**
19 **an expert in gender dysphoria or gender discordance?**

20 A No.

21 **Q Can you please identify for the record what**
22 **specific qualifications you have to hold yourself out as**
23 **an expert in issues relating to gender identity?**

24 A I've seen probably over 16,000 children,
25 adolescents, families in my career. This is a group of

1 individuals who, with the range of psychopathology what
2 we call internalizing disorders, anxiety, depression,
3 fearfulness, so forth. Externalizing disorders,
4 aggression, conduct problems, depression, suicidality,
5 and so the areas that I've published in have been
6 conduct disorders, eating disorders, family system
7 dysfunction, and so forth. Now, so I would make the
8 point that I am not a specialist as some individuals who
9 that's all they see. I've seen a lot. And -- and in
10 that sense, I believe I'm uniquely qualified to describe
11 where this fits in with the range of psychopathology.
12 How unique is it, and how different is it? And in our
13 field, we've had numerous diagnoses that have waxed and
14 waned. They come and go, and it's really not clear
15 where this is going, because it skyrocketed at this
16 point. Now, I have -- because they're there and they're
17 growing, in the last number of years seen many more
18 cases. I think I used the estimate of 60. I've added
19 two new ones this week. It's just growing all the time.
20 And why I do this, and feel I can do this, I consult
21 with colleagues, I read, I study, I see what's in the
22 clinic, I treat my patients, and so that's what I would
23 say in terms of why I'm qualified.

24 **Q Okay. When you consult with colleagues, who**
25 **do you mean you consult with exactly?**

1 A Well, those that do psychotherapy. I have
2 four or five in our clinic. We -- we talk about these
3 cases. Actually, several others. Nationally, I have
4 some friends, very experienced child psychiatrists. We
5 talk about these things. And I'm in discussions right
6 now with some individuals in our family committee. I'm
7 preparing a presentation next year. I'm not sure it'll
8 happen, but some of us want to, regarding the issues
9 with families of transgender students and how to help
10 them.

11 **Q Within your clinic, you said -- who are the**
12 **people that you consult with in your clinic?**

13 A Well, it would be Dr. Brady. A good number of
14 my faculty have discussed, Dr. Peters, Dr. Lohr, Dr.
15 Kaur, and a number of others. Now, they have more --
16 various degrees of experience, so Dr. Christine Brady
17 has begun to identify herself as -- as having an
18 interest in this patient population, and wants to
19 develop expertise in it. I think the others are busy
20 doing other things. Dr. Peters and I, as he directs the
21 clinic, we really need to develop ways to help the kids
22 better, and get the kids into the kind of programs and
23 assessments they need.

24 **Q Which -- so Dr. Christopher Peters directs the**
25 **Bingham Clinic?**

1 A He -- we haven't informally kind of announced
2 that, but -- so I'm the overall administrative head, but
3 in day-to-day clinical matters, I'll be asking him to
4 assume more responsibility. He has been our director of
5 training up until this point.

6 **Q Okay. And which -- what specific involvement**
7 **do you have in rendering care or treatment for the**
8 **transgender patients that you say you see?**

9 MR. KOSTELNIK: Form.

10 A I have a limited psychotherapy practice. I
11 accept patients for psychotherapy. I've actually had
12 two who have been in ongoing therapy, and the
13 adolescents developed a transgender orientation during
14 care for other issues, which is an interesting
15 phenomenon. I see them at my consultation at the
16 treatment center and also when I round -- we have an
17 inpatient service, so that -- the 60 cases I mentioned,
18 I've seen them in different settings.

19 **Q And this is all at your work with the Bingham**
20 **Clinic?**

21 A Right. Right.

22 **Q Okay. And who would have those -- access to**
23 **those records of your treating those patients?**

24 A Well, I -- I would. And -- and they're in
25 different places throughout my career. You know, when I

1 was asked this, I had to go through and make estimates
2 of when I saw certain cases and where and so forth.

3 Q Do you have a psychotherapy practice that's
4 separate from Bingham Clinic that's on your own?

5 A No. No, I don't.

6 Q Okay. You mentioned that you consult with
7 friends nationally. Who are the friends you consult
8 with?

9 A Colleagues. Dr. Douglas Kramer in Wisconsin.
10 Dr. John Sargent in Boston. Dr. Sam Fieldman ,
11 Asheville, North Carolina. Dr. Leigh Bishop, Houston,
12 Texas. You know, I've consulted with them around lots
13 of issues over the years. As I've done more transgender
14 work, we've discussed cases a little more on that.

15 Q You mentioned that Dr. Peters is going to be
16 taking over more on the day-to-day activities at the
17 clinic. Did someone ask you to step down or...?

18 A No one has asked me to step down, but I'm, at
19 this point in my career, looking at having our clinic as
20 strong as it possibly can be when I transition into
21 retirement. I haven't picked a date yet, but -- so in a
22 complex operation like we have, one needs to think ahead
23 --

24 Q Do you have --

25 A -- but I've not been asked to step down.

1 Q Have you been asked to relinquish any of your
2 duties at the Bingham Clinic?

3 A No.

4 Q And you don't have a retirement date in mind?

5 A Not specific, no.

6 Q Or general?

7 A General might be four years -- three or four
8 years. I'm not sure.

9 Q Are you currently the treating physician for
10 any transgender patient?

11 A For psychiatrist, yeah.

12 Q How many?

13 A I think five.

14 Q Are they patients of the Bingham Clinic?

15 A Two are, and three are not.

16 Q What are -- where are the other three?

17 A The other three are in the residential
18 treatment center.

19 Q At Buckhorn?

20 A Yes.

21 Q Okay. What are the names of the five
22 transgender patients that you're currently treating?

23 MR. KOSTELNIK: I'm going to object at this
24 point. That's HIPAA protected. I'm not going to
25 allow him to answer.

1 Q Okay. Would --

2 A Yeah, I thought we'd covered that, but...

3 Q I'm still allowed to ask, and he can make his
4 objection, but the records for the five -- those five
5 patients, would they all be kept at the Bingham Clinic?

6 A Certainly the two I'm seeing at the Bingham
7 Clinic would be. The three at Buckhorn would be at
8 Buckhorn. They would have a consultation note for me in
9 their record. Yeah.

10 Q Is there a gender clinic at the University of
11 Louisville Medical School?

12 A The department -- Division of Endocrinology
13 has a gender clinic. Dr. Brady consults to that clinic.
14 We're in the early stages of negotiation and discussion
15 how we could in our own division of child psychology,
16 and I think it will happen at some point, probably under
17 Dr. Brady's leadership, of the mental health component
18 to that. And this is also new, I would emphasize again.
19 People were not talking about this. They just decided
20 in Boston ten years ago to do this, and it spread
21 throughout the country quickly; in our facility, just
22 within the last five years. And so how the Division of
23 Endocrinology relates to child adolescent psychology and
24 who does what is still getting worked out because there
25 are two -- two roots for these patients to come in.

1 Typically individuals will see a physician or
2 a pediatrician and believe they're possibly transgender
3 and then come to the endocrine clinic. They do have a
4 brief psychological assessment: does it look like
5 transgender, change in medical interventions, whether
6 they should be used, and then they proceed or if -- if
7 there's a delay in that because of psychopathology
8 problems, then that takes place, and Dr. Brady makes
9 that call. That's one root. The other is how I have my
10 patients: people come in with all the range of problems,
11 what we call "psychopathology", that these kids have --
12 many of them. They're depressed, anxious. And in the
13 process of doing what we call "work-up", doing all the
14 things that we do, we find they have a gender identity
15 issue. They're either in the process of transitioning
16 or want to transition, have questions about it, wonder
17 about it, and as we work them up, then that becomes a
18 part of it. And that's --

19 **Q Uh-huh.**

20 A We really need to have that organized in our
21 clinic.

22 **Q In your work, if you're evaluating or treating**
23 **a patient and they do tell you that they have a**
24 **cross-gender identification --**

25 A Yeah.

1 Q -- do you refer them to the gender clinic so
2 they can receive gender-affirming treatments?

3 A No. I pursue a thorough psychiatric
4 evaluation for -- and that means exploring their life.

5 Q Uh-huh.

6 A An exploration of all the issues that are
7 related to them. And people, as I said earlier, in a
8 transition of adoption of transgender, half of them
9 aren't sure, and as you know from the literature, that
10 many of the younger ones then change their minds. It's
11 a fluid state. So we need to explore and do what I call
12 "good psychiatry" to figure out -- now, once it's clear
13 -- and sometimes younger persons, maybe 15,
14 16, are very definite that they want to pursue a medical
15 intervention. The next step is making sure the family
16 is in support, that they give an informed consent, then
17 we would refer over. Yes. But -- but it's a -- for a
18 medical treatment, but let me be clear: We affirm all
19 the patients in our clinic and believe in them and
20 support them and take care of them. Now, the idea that
21 I'm male or -- when a female would say that or vice
22 versa, we explore that and try to understand how -- how
23 that came to be --

24 Q Uh-huh.

25 A -- but do not take that away from them if they

1 maintain that over -- over a period of time.

2 Q Okay. So have you -- after you've done the
3 exploration that you just described, have you referred
4 any patients you've treated to a gender clinic at U of
5 L?

6 A We're -- we're doing that more. I think --

7 Q But yet -- have you: yes or no? That's my
8 question.

9 MR. KOSTELNIK: Form.

10 A The -- not the gender clinic. I've referred
11 one young man I'm working with to another psychiatrist
12 in town who has claimed some specialty expertise.

13 Q So --

14 A And that was --

15 Q Okay.

16 A The family was going to find that person. I
17 haven't got his name yet. But that was one of the
18 patients I've treated. Over a period of time, it became
19 clear that that was his identity. His family was really
20 in no shape to make any decision either way, and I felt
21 it was in his best interest to see -- see another
22 psychiatrist.

23 Q Who is the psychiatrist you referred that
24 patient to?

25 A I -- again, the mother is looking at that. A

1 A Probably more of -- he is such a confused,
2 disorganized kid. Someone needs to sort through this
3 and help him with his identity, and once it got clear,
4 then he could go to that clinic. I mean, potentially he
5 could go to that clinic now, but he is so disturbed, I
6 -- I really think it would be a waste of the clinic's
7 time because they wouldn't give him hormones just yet.
8 To show you an example, he's not even in school. He --
9 he's at home with his parents -- one parent and
10 grandparents who are disabled. So it's -- yeah.

11 **Q How old is the patient?**

12 A 16.

13 **Q 16. So gone through puberty?**

14 A Yes.

15 **Q And has a transgender identity that he's**
16 **expressing?**

17 A He said -- yeah. He -- he said it developed
18 -- he was actually working with one of our social
19 workers. It developed about 18 months ago. He declared
20 that he was -- felt he was a woman. And the social
21 worker worked him for a while and then referred him back
22 to me. He's been in the clinic a long time. Yeah.

23 **Q And he's never been to the gender clinic to**
24 **see Dr. Brady?**

25 A He has not, although, actually, that's not a

1 bad idea. If -- the mother is so disorganized. If she
2 does not come up with good enough names, we might do
3 that.

4 Q Because the -- part of the gender clinic, you
5 don't just walk in and demand hormones and get hormones,
6 right? They do an evaluation with Dr. Brady, right?

7 A Well, yeah, but -- I don't know. Some --

8 Q You don't know? Do you know what the process
9 is when transgender patients come to the gender clinic?

10 A Pretty much. Yeah. I -- some -- with some of
11 the patients that I've been aware of, it comes pretty
12 close to coming in and saying, "This is what I want,"
13 and -- in a brief -- very brief interview, then the
14 plans are made for a medical intervention, so --

15 Q Which patients are those that have just come
16 in and very quickly gotten medical therapy?

17 A I don't -- I don't know the names.

18 Q Okay.

19 A I've been aware just of some that have been
20 presented to me.

21 Q How are you aware of that?

22 A I attended the clinic one -- one morning,
23 discussed the cases with Dr. Brady.

24 Q So you've been to the gender clinic how many
25 times?

1 A I was there once.

2 Q When?

3 A I don't know the day. It was a few months
4 ago.

5 Q Have you treated any patients at the gender
6 clinic?

7 A At the clinic, no. No.

8 Q Have you evaluated any transgender patients at
9 the gender clinic?

10 A I was part of an evaluation -- a couple of
11 evaluations that were done that morning.

12 Q What did you -- what was your involvement in
13 those couple of evaluations?

14 A Pure observation.

15 Q So you didn't talk?

16 A I chose not to ask any questions. It was just
17 easier for Dr. Brady to do her work.

18 Q And that was your decision to not talk to the
19 patients?

20 A Absolutely. Yeah. I've done it many times in
21 my career as I've educated doctors, physicians,
22 psychologists. It's best to discuss it after rather
23 than interrupt their work.

24 Q You don't supervise Dr. Brady's work at the
25 gender clinic, correct?

1 A I do not. I'm -- I'm overall clinically
2 responsible for any activities in our division, but no,
3 she's an independent practitioner. She doesn't have a
4 supervisor.

5 **Q And she works with Dr. Kingery, the pediatric**
6 **endocrinologist; is that right?**

7 A Yeah. That's their -- part of their team over
8 there. That's correct.

9 **Q Let me just step back to the earlier line of**
10 **questions just for a second. Can you identify for the**
11 **record what specific qualifications you have to hold**
12 **yourself out as an expert in gender dysphoria?**

13 MR. KOSTELNIK: Objection. Form.

14 A I haven't held myself out as an expert.

15 **Q Okay.**

16 A I'm an expert in child and adolescent
17 psychiatry, family psychiatry, developmental
18 psychopathology, and that's what I do. Yeah.

19 **Q Okay. Are you holding yourself out in this**
20 **case as an expert in issues relating -- I'm sorry. Let**
21 **me strike that. Are you holding yourself out in this**
22 **case as an expert regarding transgender healthcare?**

23 A I feel -- feel I am qualified and fully
24 conversed in the issues about transgender healthcare
25 and, over the last several years, have dramatically

1 increased my involvement with these patients and seeing
2 kind of how it fits or doesn't fit with development
3 psychopathology and family psychopathology, other
4 problems. But when you say holding yourself out, I --
5 it's kind of an interesting term I'm not sure how to
6 interpret.

7 **Q Any other qualifications that you would say**
8 **make you an expert in transgender healthcare or -- well,**
9 **let me strike that. So are you saying you are an expert**
10 **in transgender healthcare or not?**

11 MR. KOSTELNIK: Form.

12 A I don't know what definition of "expert"
13 you're using.

14 **Q Well, you're identified as an expert witness**
15 **--**

16 A Well, an expert --

17 **Q -- in this case, right?**

18 A I -- I would say yes in the sense of that I
19 know a great deal about adolescent psychopathology, how
20 kids develop problems, all the psychiatric disorders
21 that many transgender kids have, and am quite adept at
22 sorting out what's cause and effect; in other words,
23 what -- what issues do the transgender experience cause
24 or what predisposing factors kind of lead to transgender
25 issues, all of that kind of -- kind of thing. I'm very

1 expert, and maybe more expert than some who -- to use
2 the phrase, "If all you have is a hammer, everything
3 looks like a nail." I mean, to -- to take these -- in
4 fact, I have said this publicly recently that this is
5 becoming the only disorder in medicine that it appears
6 in some cases, we make the diagnosis based on what the
7 patient tells us. In other words, they have it, so
8 that's what we do. And it's -- you need to approach it
9 in a different way.

10 **Q At the gender clinic, does Dr. Brady approach**
11 **it that way? If some -- a patient comes in a tells --**

12 **A I'm not sure --**

13 **Q Excuse me. Just let me finish.**

14 **A Okay.**

15 **Q If the patient comes in and just says, "This**
16 **is who I am," then they just accept that?**

17 **MR. KOSTELNIK: Form.**

18 **A I -- I doubt that she does that. There's a**
19 **range of responses, and you'd have to ask her. I don't**
20 **know.**

21 **Q Okay.**

22 **A She has that kind of --**

23 **Q Do you know of any --**

24 **A -- practice.**

25 **Q -- gender clinics where they just -- the**

1 patient comes in and just says, "This is what I need,"
2 and they just rubber stamp it and do what the patient
3 wants, not evaluating them?

4 A Nobody would tell you that, but I've talked
5 with individuals who say that's basically what happens.

6 Q Who -- which --

7 A In other words --

8 Q Which individuals --

9 A In other words --

10 Q -- say that?

11 A In other words, people -- once they come in,
12 they're rarely turned around, and the level of
13 psychological evaluation is questionable. Now, in the
14 standards of care and so forth, it's certainly demanded
15 and expected. My point is: You need to take time and
16 give some time to sort through these issues. But -- but
17 there are clinics where it's -- the -- the affirmation
18 of the patient is confused with affirmation of the
19 diagnosis. Every patient should be affirmed, cared for
20 --

21 Q Okay. But my question was: Which specific
22 individuals say that's what happens, that a patient
23 comes in and demands something and that's rubber
24 stamped?

25 A I -- this is my impression. I -- this is a

1 very specific question, but Dr. Ruse would be one
2 individual who's had experience with -- see, these
3 clinics -- not everyone has one of these clinics, and
4 they're just popping up all over the place. So --

5 **Q Dr. Ruse doesn't treat at the gender clinic**
6 **where he works, though, right?**

7 A That's my understanding. Yeah. He's a
8 researcher. Yeah.

9 **Q Okay.**

10 A But -- but he --

11 **Q Anyone else besides Dr. Ruse?**

12 A With respect to the question of the
13 thoroughness of the evaluation, I've heard a couple of
14 presentations in grand rounds where it's not been clear
15 how thorough the psychological evaluation is. And
16 again, I would emphasize everyone says they do it. I'm
17 not sure how thorough it is.

18 **Q Can you identify any practitioner who does not**
19 **do a thorough job and just accepts what --**

20 A No. I'm --

21 **Q -- the patient wants?**

22 A -- not going to do that.

23 **Q Okay.**

24 A I can't.

25 **Q Okay. You said -- used the phrase "rarely**

1 **turned around". Did you mean at the clinic, it's rarely**

2 --

3 A In other words, they come in. They request a
4 treatment for transgender. "I'm transgender. Let's
5 start that process." In other words, the process of --
6 after a thorough evaluation. It seems that what you're
7 saying is not clear, so let's continue to try to sort
8 through your issues, your depression, your anxiety, your
9 fearfulness, and see how much transgender is -- is there
10 after you talk.

11 Q Do you -- is it your opinion that it should be
12 the goal at those gender clinics to turn people around
13 and say, "You're not transgender" --

14 A No. It's a --

15 Q -- "you don't need treatment"?

16 A It's the goal to determine what is the cause
17 of symptoms and how to map out treatment. Yeah.

18 Q Is it your opinion that efforts should be made
19 to align patients' natal sex with their gender identity?

20 A No. The opinion is to make a thorough
21 diagnosis and, as you know, many kids change their mind,
22 younger kids in particular. It's called desist.

23 Q I'll get to -- I have --

24 A Kind of --

25 Q -- a lot of questions about desistence --

1 A Okay. Well, then --

2 Q -- later.

3 A -- I guess we'll do that this afternoon, then.

4 Q **Yeah. No, I know what you're talking about.**

5 A But no, I -- that -- your question about
6 alignment; it's so important. I want you to make --
7 make sure I understood that, but it's not the goal when
8 someone comes in to get them to align, no, just as it
9 should not be the goal when someone comes into a
10 transgender clinic to immediately agree with their sense
11 that they're the opposite sex. You thoroughly evaluate
12 this incredibly complicated situation is what you do.

13 Q **Didn't you put in your report, though, that in**
14 **some cases, efforts in aligning gender identity with**
15 **their sex should be done in order to reduce stress?**

16 A Sure. In some cases; that's a key phrase.

17 Q **What's your -- what are the some cases where**
18 **efforts should be made to align gender identity with**
19 **birth sex?**

20 A When it becomes clear in assessment of the
21 family and the youth that their fearfulness -- and it
22 often involves anxiety and fearfulness of being involved
23 -- expected to behave in a certain way if you're a
24 genetic female, and that the overwhelming nature of that
25 is led to, "Well, maybe I should be a male." And

1 wanting to be male of course doesn't mean that you are
2 one, but you explore that and you ask how they came to
3 this conclusion and what are some of the other things
4 that they -- what is so difficult about being a woman,
5 and all the things that high-level psychotherapy
6 involve. And after that time, like this patient I'm
7 referring, it's clear that -- to use the phrase, "He has
8 made his mind up," and -- after that exploration, and
9 then they should be free to have medical altering
10 procedures, but -- but after thorough exploration.

11 **Q Okay. But -- so are you saying that a person**
12 **will become transgender in order to escape society's**
13 **expectations for their sex?**

14 A I don't know if I'd put it that way: they
15 decide to escape. It's just they -- they can't -- so --
16 so as an example, what happens is -- and I'm more
17 familiar right now with -- because I'm dealing with a
18 lot of young women. They've seen their mothers abused,
19 they've been abused, the -- the perceived expectations
20 of what happens when you relate as a male or things that
21 -- that are intolerable. One of my patients
22 said, you know, "I just" -- "when I was" -- "when I was
23 a female or a girl, all kinds of bad things happened."
24 And so there's a removal from that. So the -- the
25 dynamics are complex would be the simplest way to put

1 it. And so it's not that they decide to -- to avoid
2 this. It's that they're incapable. And the increasing
3 literature search is -- research is coming out that many
4 of these kids are quite disturbed. And so what is --
5 what is the nature -- the key question of: What is the
6 nature of the relationship? How did this develop? What
7 is it? How do we understand that? And...

8 **Q Okay. Is it your opinion that if someone**
9 **suffers from abuse, that is a reason they would become**
10 **transgender?**

11 A Not -- not in and of itself because many kids
12 have abuse and do not become transgender, but I think
13 the -- the well-adjusted, non-psychiatric symptom kid --
14 we -- we have to grapple with: Why are there so many
15 psychiatric disorders in this group -- I'm talking
16 specifically about adolescence -- and what are the
17 mechanisms? And -- and these things have not been --
18 been sorted out. The science is unsettled.

19 **Q Well, there is a lot of literature saying that**
20 **-- and, in fact, I'm pretty sure it's WPATH that says**
21 **that stigma and discrimination, and you yourself**
22 **admitted that the transgender youth face discrimination**
23 **and stigma. Isn't that a reason that transgender youth**
24 **could have difficulties?**

25 A A reason.

1 MR. KOSTELNIK: Form.

2 A A reason --

3 Q **Okay.**

4 A -- sure.

5 Q **Okay.**

6 A But not the only one. And it's presented as
7 the model -- as the only one, and it's inconceivable
8 that all these -- the pathology is high, ten times the
9 incidence of suicide as the normal -- various studies
10 rank it different, but a recent study that just came out
11 from Finland is saying, you know, we thought these kids
12 would come for reassignments, endocrine treatments, and
13 were overwhelmed with how disturbed they were. And that
14 was a new idea to them, and the literature is trying to
15 grapple with -- with that.

16 Q **Which Finland study are you referring to?**

17 A It's in my list. It's Hytola, I think, and
18 colleagues.

19 Q **It's in your report or your rebuttal?**

20 A No. It's in -- it's in the report in the
21 exhibit, I believe.

22 Q **In your bibliography?**

23 A Yeah. And so my point is it -- that doesn't
24 end it all either, but it's not a simple thing that
25 these kids are healthy and that they have hormones

1 treatments, physical treatments, and then they avoid
2 suicide and the suicide potential is thus treated.

3 Q Okay. Well, I'll ask you some more questions

4 --

5 A Yeah. It is --

6 Q -- about that later.

7 A Okay. Sure.

8 Q Now, my -- I mean, trying to align gender
9 identity with birth sex; isn't that trying to change
10 someone's gender identity?

11 A If that was your specific goal to align --
12 that -- and that's what you were trying to do, that
13 would -- would be -- I...

14 Q Isn't that considered conversion therapy or
15 reparative therapy?

16 A I think that's what people mean when they --
17 but conversion therapy, it should be noted, is really a
18 meaningless term, meaning -- it really applies to
19 adults. You can't convert something that's not even
20 there. In other words, changing an identity, a
21 personality; that's an evolution. And in our field, it
22 has never been accepted as kind of being complete. The
23 end is kind of arbitrary, but 16, 18, 20 -- you know,
24 when you can more or less say someone has their
25 personality that then wanted to convert one from.

1 Q So you're --

2 A So conversion therapy for 6-year-olds is
3 meaningless is my point.

4 Q So you would think there would be no harm with
5 conversion therapy for a 6-year-old?

6 A It just wouldn't -- wouldn't be done. What
7 you would do with a 6-year-old is -- is provide
8 developmental parental guidance.

9 Q Well, some 6-year-olds have gender dysphoria,
10 right, and they're persistent, consistent, and insistent
11 on their gender identity being a certain --

12 A Well --

13 Q -- thing, right?

14 A -- that's --

15 MR. KOSTELNIK: Form.

16 A Yeah. There are a few kids like that.

17 Q Okay. So if you tried to change that
18 6-year-old's gender identity, isn't that conversion
19 therapy or --

20 A Well, that's not how --

21 Q -- reparative therapy?

22 A -- you do it. I mean, if that was your goal
23 to change that, your goal would be to have a healthy
24 child. And what's a conservative position, which I
25 espouse, is that you guide them in the developmental

1 challenges. And so if you have an effeminate boy, for
2 example, try to find peers that have interests that are
3 more, shall we say, artistic or feminine in -- that we
4 would use in our culture, and not try to change them,
5 but guide him or her. One of the things that -- because
6 you've used the phrase, I'll follow up on it.

7 Insistent, persistent, and consistent; when
8 people use that -- I'm going to ask your permission to
9 be sarcastic for a minute. But the question that comes
10 for me is: Do you know anything about children? Half
11 the things that children do and want to do are
12 accompanied by insistent, consistent, and persistent and
13 driven feelings. And the healthy parent recognizes what
14 should happen and stops, sets limits, guides, is
15 supportive, is affirming. And so 3-, 4-, 7-year-old
16 children know very little about reality in an ultimate
17 sense, and it's the parents' job to guide them.

18 **Q So you don't think any children can have a set**
19 **and firm gender identity at any point?**

20 A I didn't say that. I would say if you think
21 that's true -- there are a lot of questions, and many
22 parents are --

23 **Q If -- I'm sorry. If I think what's true?**

24 A That it's firm, whatever.

25 **Q Well, there's studies showing that children --**

1 in fact, I believe your colleague, Dr. Kingery, has
2 written this as well that gender identity for children
3 can be stable and fixed by the age of 4. Do you
4 disagree with that?

5 A Well, let's take it to a broader question --

6 Q Well, no. Can you answer my question? Do you
7 agree with that or not?

8 A For some cases, yes.

9 Q Okay. Do you think that transgender children
10 can have a firm and consistent gender identity or only
11 cisgender children?

12 A I think both, but I think transgender would be
13 extremely rare with what we know, and that the way to
14 approach it is not -- clinically what I've seen is
15 parents stand off and watch children, and they're very
16 -- and I've had experienced clinicians say, "Well, we
17 tried to encourage a young boy in a certain direction
18 and he cried and he was so and" -- "I don't want to."
19 And so that was my comment then to go back, "Well, don't
20 you understand that children resist things that they
21 don't want to do, and it doesn't mean necessarily" -- we
22 don't know enough about when these things become firm
23 and set.

24 Q Well, there is medical literature saying that
25 it could be by age 4, correct?

1 A It could be, sure.

2 Q Okay.

3 A And it's --

4 Q So --

5 A -- true with most traits. Yeah.

6 Q -- what -- you mentioned you're trying to
7 steer a boy -- an effeminate boy away and to find him
8 peers. Why are -- what is wrong with being an
9 effeminate boy? I don't understand.

10 MR. KOSTELNIK: Form.

11 A There's nothing wrong with being an effeminate
12 boy --

13 Q Okay.

14 A -- but to -- to assume and assure him that,
15 "You're a boy, but you have these various interests,"
16 and that, "You don't have to be a girl to give away
17 these various interests."

18 Q And you would try to tell him, if he was
19 identifying as a girl, that, "You're not a girl"?

20 A Oh, I think it's very important to tell him
21 the facts --

22 Q So --

23 A -- the facts of things.

24 Q -- yes; is that correct?

25 A "You are a boy, but you" -- "you have these

1 feelings" --

2 Q But --

3 A -- "so let me help you with that."

4 Q Okay. But specifically, would your treatment
5 in that situation -- your recommended treatment or
6 advice for parents be to tell that boy who is saying
7 he's a girl, "You're not a girl. You're a boy"?

8 A In the supportive, loving, caring, affirming
9 terms, that's correct.

10 Q Okay. Do your colleagues at U of L know that
11 that's your recommended treatment for children
12 expressing gender dysphoria?

13 A I think some of them do and some of them
14 don't.

15 Q Which ones know about that?

16 A I -- I don't -- couldn't give you kind of a
17 listing of either/or, but...

18 Q The ones that do know; do they disagree with
19 you?

20 A Some of them do. Yeah.

21 Q Does Dr. Brady disagree with you about that?

22 A I think she does.

23 Q Okay. Anyone else?

24 A There -- there may be several others. I just
25 haven't talked with...

1 Q Does anyone at --

2 A But --

3 Q I'm sorry.

4 A Yeah. So there would -- there would be
5 others. This is something that -- as I've tried to run
6 the division and it's such a divisive issue, I've tried
7 to be thoroughly academic and discuss this, but I'm not
8 sure how easy it is to do that. We're just working
9 through that right now.

10 Q Does the dean of medicine disagree with you on
11 that?

12 A I haven't talked with her about this.

13 Q Have you talked to her about your
14 participation as an expert witness in this case?

15 A I've -- I've talked to our chairman about
16 this, and I'm sure he's told the -- the dean of the
17 School of Medicine.

18 Q What's the chairman's name?

19 A Dr. Charles Woods.

20 Q Have they seen a copy of your expert report in
21 this case?

22 A I don't think so. I'm -- I'm -- I don't know.
23 Would that be possible for that thing to be seen by
24 other people? And I'm -- I'm not sure -- so the -- that
25 my chairman is aware of any consulting opportunity that

1 I have and have done over the years in my whole career
2 --

3 Q So you --

4 A -- but -- but I'm not doing this as an
5 employee of the School of Medicine. I don't know how
6 this comes up or why this is relevant. I'm -- I'm an
7 independent expert witness, just as I would be for a --
8 as I was in a loss of life case recently. It just -- I
9 do this as part of my extra work.

10 Q Okay. And you don't disclose this extra work
11 as an expert witness to anyone at the University of
12 Louisville?

13 A Absolutely, I do.

14 Q Who do you disclose it to?

15 A Dr. Woods.

16 Q Okay. Anyone else?

17 A It's -- the way we're structured, the chairman
18 or the individuals who -- who know this.

19 Q When did you disclose to Dr. Woods your
20 participation in this case?

21 A In this particular case -- I don't go case by
22 case. He's aware of it now, obviously, because of your
23 request for records and all of these kinds of things --

24 Q Okay.

25 A -- from the University of Louisville. Yeah.

1 Q So that's how he became aware?

2 A He might've known before.

3 Q Were you ever --

4 A When I began this work three years ago, Dr.
5 Woods and his predecessor, I became aware of precisely
6 the thing that we're going through right now, that this
7 was a divisive issue, that there were those who
8 disagreed, and I wanted them to know, and they both were
9 aware all the way along.

10 Q Were you required to show a draft of the
11 report in this case to anyone at the school?

12 A No --

13 Q Okay.

14 A -- because it's my independent work.

15 Q Okay. Did you show a draft of this report to
16 anyone besides counsel for the defendant?

17 A No. Again, I should be clear: I do this as
18 an independent consultant. It has nothing to do with
19 the University of Louisville. That happens to be my
20 employer.

21 Q What research or studies have you done to
22 evaluate the impact on telling a child who is
23 identifying -- who has a cross-gender identification to
24 tell them that, "That is not your real identification"?

25 A I haven't done any --

1 MR. KOSTELNIK: Form.

2 A -- research on that.

3 Q **You haven't done any studies?**

4 A No. Now, I've taught child development and
5 development psychopathology for years, and I think the
6 number one need of children is to be guided by their
7 parents, and I've said this in the report at several
8 points. In the accuracy of the world, you don't teach a
9 child something that's not true. And so at the heart of
10 my response here, I guess, and at the heart -- maybe at
11 the heart of this case is the different between the
12 objective fact of sex and the subjective feeling of
13 gender. And so it's empathic, it's good parenting, to
14 tell the child, "You are a boy." Now, if he says, "I
15 feel like a girl," or -- but 4-year-olds don't. They
16 want to play with toys. They don't -- it's very early
17 on, and many experts over the years -- this is not new
18 -- have taken the approach of caution, guidance, and --
19 and if there is some -- which we don't know, and again,
20 the science is unsettled, some biological taint that's
21 there to influence, it will become clear, and then this
22 classic phrase of, "It's who you are or who I am," an
23 empathic parent should identify that. My point is that
24 you should not identify that too early before it's
25 clear.

1 Q When is too early? In other words, at some
2 point, do you accept that someone can have a gender
3 identity that is real and authentic?

4 MR. KOSTELNIK: Form.

5 A Oh, I think so. But -- but with children,
6 it's an evolution. 3 is too young.

7 Q Okay. At what age do you think someone can
8 have a transgender identity that --

9 A Now, this -- this would be a minority. The
10 main issues right now --

11 Q I'm sorry. This would --

12 A There -- there are two groups to consider:
13 children and adolescents. For a child to believe that
14 they are the opposite gender to their natal sex, we
15 don't know how many cases there are like that out there.

16 Q You don't -- we don't know how many people are
17 transgender in the world?

18 A Well, no. We -- we know that, but --

19 Q Okay.

20 A -- I'm talking about the developmental process
21 and -- because I thought we were talking about early on.

22 Q Well, I was wanting to know -- so do you -- is
23 it your position that adolescents are capable of having
24 a gender identity that is transgender, but children are
25 not?

1 A Very close to that position. The reason is
2 fundamentally true about development, that adolescents
3 begin to make sense of the world and can begin to
4 organize their thinking much more clearly. Put simply:
5 What parent would allow a 3- or 4-year-old decide
6 anything about what they want to eat or go to bed or --
7 and so to let them decide this, it's just -- yeah.

8 **Q Okay. I understand what you're saying.**

9 A Good, because that's -- I want to be real
10 clear on that.

11 **Q Right. And I've heard your Heritage**
12 **Foundation speech that is along those lines as well. You**
13 **referenced that -- you said your role in this case is**
14 **distinct from your role at the University of Louisville,**
15 **but you identify yourself in your report as the CEO of**
16 **the Bingham Clinic at Louisville, correct?**

17 A Yeah, and I -- that's just by form, and I
18 thought that's what you people like, you know? I mean,
19 I -- the facts of -- I'm not sure you would accept
20 opposing counsel say, "He's a good guy. I found a
21 doctor. He just works somewhere." It's just form. I'd
22 tell you my address, too, if you wanted to know where I
23 lived, too.

24 **Q Do you believe a person can voluntarily change**
25 **their gender identity?**

1 A I think that question is too black or white or
2 too simple. I -- I think it would be very difficult. We
3 always need to think about age when we're talking about
4 this area. It would be very difficult for an adult, but
5 there are instances of adults changing their identity
6 going back. Now, many of them are very troubled and
7 distressed when they've gone along with a sex change
8 operation. So -- but the younger the person, the more
9 fluid.

10 Q Okay. So do you agree with the American
11 Academy of Pediatrics that you -- a person cannot
12 voluntarily change their gender identity --

13 MR. KOSTELNIK: Form.

14 Q -- regardless of their age?

15 A Well, that's a poorly worded statement. I
16 mean, to just voluntarily state that -- you can
17 voluntarily do a lot of things that you don't, you know,
18 think you can, but at any age, yeah, that would be an
19 extreme statement.

20 Q Okay. So you don't agree with that statement?

21 A Well, I'd have to see it in context of what
22 the entire statement was. I -- I've seen the guideline,
23 but I -- yeah.

24 Q Do you believe that a gay person can change
25 their sexual orientation voluntarily?

1 A Well, again, voluntarily is -- is a -- makes
2 it sound like it would be easy, but there are instances
3 where patients, either transgender or gay, change their
4 orientation. Yes. It's not easy and it's not maybe
5 necessarily voluntary, but if they want to pursue that
6 and work with typically a therapist, a lot of times it
7 requires that, then it could happen.

8 **Q Have you ever engaged in conversion or**
9 **reparative therapy to change a person's gender identity?**

10 A No.

11 **Q Okay. Have you ever referred someone for that**
12 **kind of treatment?**

13 A No.

14 **Q Have you ever engaged in conversion or**
15 **reparative therapy for a homosexual patient to try to**
16 **change their sexual --**

17 A No.

18 **Q -- orientation? Do you have any experience in**
19 **that whatsoever?**

20 A I've got a fair bit of experience, not so much
21 now that I deal with children. So working with
22 homosexual patients, understanding their stories, and
23 the conflicted kind of painful decisions they've had to
24 make and try to help them with whatever symptoms they've
25 had, but no, I don't do reparative therapy.

1 Q But did you ever engage in efforts to help --
2 or in your -- to change someone's sexual orientation
3 from homosexual to heterosexual?

4 MR. KOSTELNIK: Form.

5 A No. Now, I have worked with patients that
6 I've listened to their struggles and they're not sure.
7 Many patients aren't sure. And -- but they often didn't
8 complete or finish therapy or -- but no, I don't do
9 reparative therapy.

10 Q Okay. Is everyone who is gay conflicted and
11 struggling, in your opinion?

12 A No. No, I wouldn't say that.

13 Q Is everyone who is transgender conflicted and
14 struggling in your opinion?

15 A I wouldn't say that. No.

16 Q Okay. Do you think that gay people are
17 inherently abnormal?

18 A Inherently abnormal; are you talking
19 sociologically, biologically, medically --

20 Q Well, you used the --

21 A -- physically?

22 Q -- word "abnormal" referring to transgender
23 people in your report, so I'm wondering if you also have
24 an opinion that gay people are abnormal.

25 A I wouldn't -- I wouldn't use the term

1 "abnormal" because it's loaded with pejorative feelings.
2 I -- I care about gay people. I have gay friends. We
3 work with them; however, the condition itself, if it
4 were pursued by the entire human race, the human race
5 would cease to exist. So I don't know what I would call
6 that. Some people might call it abnormal. I would call
7 it interesting and I'll just maybe leave it at that.

8 **Q Okay. But you used the word "abnormal" in**
9 **your report referring to transgender people, right, even**
10 **though --**

11 **A I -- I --**

12 **Q -- it's pejorative?**

13 **A -- don't know what the -- what the sentence --**
14 **oh, I don't think abnormal is pejorative at all.**

15 **Q You just said it was. You said you wouldn't**
16 **use the word "abnormal" because it's pejorative.**

17 **A Well, I'd have to strike that and look back.**
18 **The -- I -- I think it's taken by people as a negative**
19 **kind of thing. When you -- you say "abnormal", you have**
20 **to have some normal standard, and of course that's a**
21 **difficult area when -- when things are fluid, as -- as**
22 **it is in this situation.**

23 **Q Do you believe that all people's gender**
24 **identity is fluid? Like, for instance, yours; do you**
25 **believe your gender identity is fluid?**

1 MR. KOSTELNIK: Form.

2 A No. Mine clearly is not for probably lots of
3 different reasons, but I think based on what's happened
4 in our culture and what's happening with human
5 development, gender appears to be increasingly fluid a
6 concept for many people. And -- and that makes sense
7 when it's totally defined by one's feelings. So it
8 could change at any moment, and of course with many
9 people it does, and with younger children, we know with
10 desisting they change back. And so -- but not for me.
11 But no, I -- I think some people have a more firm sense
12 of themselves and others is a more fluid sense, you
13 know?

14 Q So you're not -- you don't have an opinion
15 that all transgender people have a fluid gender
16 identity, right?

17 A No. No. I think some of them get pretty
18 solidified in -- in their gender identity, and Drew
19 might be one of them on the wall. We don't know yet,
20 but...

21 Q We don't know if his gender identity is
22 solidified as male?

23 A Well, no. Well, I don't think we do. He's 16
24 or turn -- about -- about 17. I think if you're a
25 betting person, you'd say yeah, it's pretty much. And

1 we know that adolescents don't desist as often as
2 children. I mean, there's more water under the bridge
3 to think developmentally about that.

4 **Q Okay. I'll come back to some desistence**
5 **questions in a minute. Let me get back where I was.**

6 MR. KOSTELNIK: While you're stopping --

7 MS. NARDECCHIA: Yeah.

8 MR. KOSTELNIK: -- what do we want to do about
9 lunch? It's 12:10.

10 MS. NARDECCHIA: We can -- we can go off the
11 record. We can just stop now.

12 VIDEOGRAPHER: It is 12:09 and we are off the
13 record.

14 (OFF THE RECORD)

15 VIDEOGRAPHER: It is 1:08, and we are back on
16 the record.

17 BY MS. NARDECCHIA:

18 **Q Okay. Dr. Josephson, how many times has a**
19 **party in litigation brought a motion to exclude your**
20 **testimony as an expert?**

21 A It has not happened.

22 **Q How many times has a court ruled that your**
23 **testimony was unreliable?**

24 A It has not happened.

25 **Q Do you remember a case called Aid for Women v.**

1 **Foulston? It was a Kansas case.**

2 A Yes. Yeah.

3 Q Okay. Didn't the court in that case rule that
4 your testimony was inconsistent and, therefore,
5 unreliable?

6 A I didn't -- wouldn't be aware of that ruling.

7 Q Okay.

8 A I mean, I -- I testified, but if that was
9 decided after that fact, I -- I wasn't aware of that.

10 Q Okay. Just so I'm clear it was the right case
11 here, you testified in 2006 in that case as an expert
12 witness in support of a Kansas law requiring mandatory
13 reporting of consensual underage sexual activity?

14 A Yes.

15 Q And --

16 A When -- when would that determination have
17 been made that it was unreliable? I didn't know that
18 until now.

19 Q Well, it's not my deposition, but -- and you
20 testified in that case that all underage sexual activity
21 is inherently injurious?

22 A I -- I can't remember. I think all underage
23 -- depends on the criteria of underage, what is
24 underage.

25 Q Well, do you recall if that was what you

1 **testified about?**

2 A Yeah. For -- for children to have sexual
3 activity is not helpful in their development. I
4 remember saying something like that. Whether that was
5 under the age of 14 or under the age of 16 or under the
6 age of 18, I don't know.

7 **Q You testified in that case that persons under**
8 **the age of 16 are immature.**

9 A Yes, I did. I'm sure -- I'm sure I did.

10 **Q And you --**

11 A Again, we're talking 11 years ago, so...

12 **Q Okay. Well, if you can't recall, you can let**
13 **me know, but if you can, then --**

14 A Okay. But it --

15 **Q -- yeah.**

16 A I'll have to make a judgment, yeah.

17 **Q And you testified in that case that persons**
18 **under the age of 16 should not be able to obtain**
19 **prenatal care or contraception, including condoms,**
20 **without parental consent.**

21 A Parents would be -- ideally be involved in
22 those types of decisions. So when you say, "You
23 testified to this," I can't remember any of that. But
24 like that last one would be consistent with my current
25 position, so...

1 Q Okay. So you would have that opinion as you
2 sit here today?

3 A Right. Parents should be involved. Yes.

4 Q Okay. I'm going to move on to -- in your
5 report, as you've mentioned today, you wrote that you
6 have evaluated, treated, and consulted with
7 approximately 60 transgender children and adolescents
8 out of the 15,000 patients you've seen.

9 A Yes.

10 Q Is that accurate?

11 A Approximately that's correct.

12 Q Okay. And how many of those transgender
13 children and adolescents have you evaluated, treated,
14 and/or consulted at the Bingham Clinic?

15 A I'm going to include the -- our inpatient
16 service, the Buckhorn service I mentioned. This would
17 be about half of them.

18 Q So about 30 patients?

19 A Yeah, roughly.

20 Q Okay. Where were the other 30?

21 A We're talking my career, so I estimated the
22 first ten were in Minnesota, and the next ten were in
23 Georgia.

24 Q Okay. That's --

25 A I mean, the next 20. I'm sorry. That's 30.

1 Q So there was ten in Minnesota and then 20 in
2 Georgia --

3 A Yes.

4 Q -- and then 30 at Bingham?

5 A Right.

6 Q Okay. Can you go back to your -- the ten
7 transgender patients that you treated in Minnesota and
8 tell me --

9 A And this would've been assessed, evaluated,
10 had clinical contact with. I did a number of different
11 things in Minnesota, so...

12 Q Okay. Can you tell me what exactly you did
13 with the ten patients in Minnesota? Like, what -- if
14 you evaluated them, if you treated them.

15 A Right. I was treating them --

16 MR. KOSTELNIK: Form.

17 A -- for psychiatric disorders or symptoms that
18 they would've been presenting with. One residential
19 treatment center had a number of them as well, and I
20 would've been treating them for depression, anxiety,
21 substance abuse, and so forth.

22 Q And ten of them happened -- ten of those
23 patients you mean in that capacity were transgender?

24 A Yes. Yeah.

25 Q What was the residential treatment facility in

1 **Minnesota?**

2 A I -- I can't recall the exact name. I'm
3 sorry. I can't recall that.

4 **Q Okay. For those transgender patients in**
5 **Minnesota, did they --**

6 A It's been over 30 years ago if you're aware.

7 **Q Yeah.**

8 A Yeah.

9 **Q Okay. For those ten transgender patients in**
10 **Minnesota, did you actually treat them for gender**
11 **dysphoria, or were you just --**

12 A No. I was treating them psychiatrically and
13 it came up -- back then, we weren't calling it gender
14 dysphoria, but the young man would say, "Well, I'm a
15 woman. I want you to call me such-and-such," and then I
16 would explore that with him and...

17 **Q Well, for this instance for this young man,**
18 **how old was he?**

19 A I want to say about 15 maybe -- 14, 15.

20 **Q Did you diagnose him?**

21 A I'm sure I used something like depression and
22 gender identity problems or gender identity not
23 otherwise specified; something of that nature.

24 **Q How did you treat that patient?**

25 A Worked on his depression. We would talk about

1 his concern in his life. To some extent, the
2 transgender issue, if I recall, was somewhat peripheral.
3 So I tried to help him with his depression and overall
4 adjustment.

5 Q Did you -- okay. Did you do anything to help
6 address the, I guess as you say it, gender identity
7 issues that he was having?

8 A I don't think so very much. I mean, we --
9 much wasn't going on back then. It wasn't a major
10 concern of his and he -- when I -- I called him by his
11 appropriate female name. He had a lot of other issues.
12 He was failing at home, failing at school; these kinds
13 of things, so...

14 Q So this person identified as female and you
15 used --

16 A Right. And I treated him as female, but...

17 Q But you're referring to him as a male right
18 now?

19 A He is a biological male. I referred to him as
20 female as best I can understand. I'm -- I'm not sure
21 I'm answering your question.

22 Q Well, I mean, the -- well, it's fine.

23 A I got your point, but I -- it's 30 years. I
24 can't remember.

25 Q Okay. And where would those medical records

1 be maintained for your -- the treatment you provided for
2 the transgender patients in Minnesota?

3 A Some would be at the -- probably University of
4 Minnesota outpatient clinic. I mean, we saw a couple at
5 the private clinic where I worked, and if I could
6 remember the name of the residential treatment, I -- I
7 would, but I can't remember the name.

8 Q What was the private clinic that you worked at
9 in Minnesota?

10 A It's called the Kiel Clinic, K-I-E-L.

11 Q What kind of work is done there?

12 A It was -- I'm not sure they're operating
13 anymore. I'm pretty sure they're not. It was a general
14 mental health clinic where I was one of the -- the lead
15 psychiatrist. It -- it had nothing to do with
16 transgender.

17 Q Okay. In any of the ten transgender patients
18 in Minnesota, did you work with them to -- or guide them
19 to have their natal sex aligned with their gender
20 identity?

21 MR. KOSTELNIK: Form.

22 A No.

23 Q None?

24 A No.

25 Q Okay. Were there any other consulting

1 **physicians you worked with with those ten transgender**
2 **patients?**

3 A Not that I recall. May have been a couple of
4 psychologists. I'm not sure.

5 **Q Remember their names?**

6 A No.

7 **Q Were any of those ten patients in Minnesota**
8 **people that you saw in the context of schools?**

9 A No, I -- I don't think so. They were -- when
10 they were in residential treatment, you know, usually
11 the school was embedded in the treatment program. That's
12 what happens there, so it wasn't a public school system
13 at all.

14 **Q When -- so is Buckhorn Residential Center a**
15 **similar residential treatment facility as the one in**
16 **Minnesota?**

17 A Yeah, it would be somewhat similar. You know,
18 Buckhorn is -- at this point, is all females. I think
19 the one in Minnesota had both males and females.

20 **Q What is the purpose or, you know, why do**
21 **people go to residential -- for -- let's focus on the**
22 **Buckhorn residential care. Why do people go there?**

23 A Because of severe psychopathology, serious
24 disturbances.

25 **Q And is any of the treatment at Buckhorn**

1 Residential Center treatment to guide individuals to
2 have their natal sex aligned with their gender identity?

3 A No.

4 Q So you've never provided that treatment at the
5 Buckhorn Residential Center?

6 A I don't know what that treatment is.

7 Q Well, you -- it's in your report that that's
8 one of your recommendations that in some cases, that is
9 the treatment that is appropriate. Is that your
10 opinion?

11 A Well, in some cases, when it's clear that the
12 clinical material would suggest that, yeah. I mean, I
13 wouldn't call it a treatment. It's a result of -- of
14 your intervention.

15 Q Okay. Well, has that -- have you engaged in
16 that kind of intervention at Buckhorn Residential
17 Center?

18 A No. No.

19 Q Have you engaged in that kind of intervention
20 with any of the 60 transgender patients you've treated
21 or evaluated?

22 A With that as a specific goal, no. I start by
23 treating general psychopathology, which is often family
24 psychopathology, which means depression, anxiety,
25 substance abuse, and maladaptations of one kind or

1 another, and so then the -- the gender issues are kind
2 of alongside. Again, these are patients that are not
3 coming with a gender specific complaint, but it's
4 uncovered in the process of psychiatric treatment.

5 **Q So you've never, in treating or evaluating any**
6 **of the 60 transgender patients, tried to guide them in**
7 **aligning their natal sex to their gender identity?**

8 A Well, just a brief comment about how
9 psychotherapy works, I mean, you explore --

10 MS. NARDECCHIA: Well, move to strike as
11 non-responsive.

12 A Okay. So no.

13 **Q I really would like an answer to my question.**

14 A I'd say no.

15 **Q No. Okay. Okay. The 20 -- I'm going to move**
16 **on to the Georgia -- the 20 patients in Georgia that you**
17 **said you evaluated, treated, and consulted with. Can**
18 **you describe what kind of treatment you provided to**
19 **those 20 individuals?**

20 A A lot of it was assessment, some of it on an
21 inpatient service. Some were -- I consulted with the
22 detention center; there would've been an assessment in
23 that context. Residential treatment also there as well,
24 and not too many patients that I was engaged in with
25 therapy, per se.

1 Q Okay. Out of those 20 patients, did you treat
2 any of those 20 patients with regards to gender
3 dysphoria/gender discordance?

4 A We would discuss it. I think I went -- you're
5 trying to treat them and change this. Again, you realize
6 this was over a period of 20 years and it was quite rare
7 then and so it was discussed. Family concerns were
8 addressed or asked about and future goals inquired
9 about.

10 Q Okay. And did you make a diagnosis for any of
11 those 20 transgender patients such as -- I know gender
12 dysphoria was not a diagnosis at that point, but any
13 kind of diagnosis regarding their gender identity?

14 MR. KOSTELNIK: Form.

15 A I'm sure a good number of them I would use --
16 would have used the gender identity disorder diagnosis.

17 Q To -- so to -- you do recall diagnosing some
18 patients with gender --

19 A Yeah. In addition to depression, substance
20 abuse.

21 Q Sorry. Let me finish my question. It's just
22 so it's clear for the record. As you sit here today, do
23 you recall specifically diagnosing any of the 20
24 patients in Georgia with the diagnosis of gender
25 identity disorder?

1 A Yes.

2 Q Okay. How many of those 20?

3 A Maybe ten, 12.

4 Q Okay. What is your -- how did you evaluate
5 them for gender identity disorder?

6 A Interviewed them. Asked them relevant
7 questions. Asked them -- you follow prompts. If they
8 felt that they were the opposite gender, I'd have them
9 tell me when that started, what some of their
10 experiences were, how they determined this, so forth.

11 Q Okay. For any of the ten patients in
12 Minnesota or the 20 patients in Georgia, did you
13 recommend further medical care for gender -- for
14 affirming their gender identity?

15 MR. KOSTELNIK: Form.

16 A Very few of them I did or recommended further
17 medical care for their psychiatric disorders and what it
18 would have done would have been note what some of the
19 therapy issues would be and gender concerns would have
20 been one of them.

21 Q Okay. Did you ever refer to endocrinologist,
22 one of those patients?

23 A Fairly rarely.

24 Q Which --

25 A That wasn't done much back then.

1 Q At Georgia or Minnesota?

2 A Both. It would be rare. I don't think I did
3 it much there at all.

4 Q How many would you say you referred to an
5 endocrinologist at Georgia?

6 A At most five, maybe three, four.

7 Q Okay. And what about Minnesota?

8 A A similar number, one, two, three.

9 Q And where would the records for the 20
10 patients that -- transgender patients you saw in Georgia
11 be kept?

12 A Would be Georgia Regional Hospital, the
13 Medical College of Georgia, would be the two facilities
14 that I saw patients at.

15 Q So did any of those patients in Minnesota or
16 Georgia actually transition gender?

17 A I lost contact with a lot of them that were
18 fairly brief. You know, I think a couple of them in
19 both places went through the next steps after I -- after
20 they left our clinic and at Medical College of Georgia,
21 we served a large area.

22 Q Okay. And you supported them in transitioning
23 gender?

24 MR. KOSTELNIK: Form.

25 A Yes.

1 Q Okay. How -- what were the ages of those --
2 of the patients that you supported?

3 A They would have been -- they would have been
4 adolescents, 15 to 18. Definitely not younger than
5 that, at all.

6 Q Okay. Okay. Now, the 30 -- approximately 30
7 transgender patients you've treated, at Bingham Clinic
8 -- well, see -- let me start back. When did you become
9 CEO of Bingham Clinic?

10 A 2003.

11 Q Okay. When did you start working at Bingham
12 Clinic?

13 A Same time.

14 Q Okay.

15 A 2003.

16 Q So from 2003 to 2017, you've had approximately
17 30 transgender patients?

18 A That'd be about right. Yeah.

19 Q And how old are the transgender patients that
20 you've seen at Bingham Clinic?

21 A Mostly teenagers, 14 to 18. Mostly teens,
22 yep.

23 Q Have you evaluated or treated any children who
24 were transgender while you've been at Bingham Clinic?

25 A I haven't treated any. Some have been

1 presented in some of our clinic case conferences and
2 I've supervised residents in their beginning
3 assessments, but I haven't treated any children.

4 **Q You mentioned the clinic case conferences. Can**
5 **you explain what that is?**

6 A To become a psychiatrist, one needs to not
7 only know the basic facts of the field, but treat
8 patients under supervision. And one of the aspects of
9 education is having them present a case in a room not
10 unlike this, people contribute, faculty supervisors say
11 this is what I think is important about the case, and
12 that's what would happen. Yeah.

13 **Q Who is typically involved -- or sorry, strike**
14 **that. Who is typically present for these clinic case**
15 **conferences?**

16 A Usually -- not all faculty, but we encourage
17 as many to come. There would be one identified key
18 supervisor and then other faculty would take part as
19 well.

20 **Q When you say faculty, do you mean a child --**
21 **in adolescent psychiatry or**

22 A Right. Yeah. And then we also have
23 psychology trainees as well.

24 **Q Okay. Is Dr. Brady part of those clinic case**
25 **conferences?**

1 A Yeah. She would be part of them. Yeah.

2 Q Does Dr. Brady supervise all of the residents
3 or interns treating LGBT patients?

4 A I don't -- I don't think she supervises all of
5 them. That would be too big a load for her and we have
6 two main type psychologists and psychiatrists. We have
7 a small psychology-training program and she would
8 supervise most of them.

9 Q Do you supervise any of them?

10 A I supervise our psychiatry residents, some of
11 them.

12 Q But the ones who treat LGBT patients you don't
13 supervise them, right?

14 MR. KOSTELNIK: Form.

15 A I -- I supervise some. Again, part of their
16 general psychiatry presentation to the clinic.

17 Q But as you sit here today, isn't it true that
18 Dr. Brady supervises the psychology and psychiatry
19 interns and residents who are treating LGBT patients?

20 A Not so much psychiatry. I'm encouraging her
21 to do more of that, but she's been thinking through how
22 she would do that. I've asked her to take over the
23 position of directing services, which would include
24 supervision, but she hasn't done that of yet.

25 Q As you sit here today, do you currently

1 **supervise any intern or residents who treat LGBT**
2 **patients?**

3 A A couple of residents -- I don't think they
4 have any on their caseload right this moment.

5 **Q Which residents?**

6 A Johanna Landinez and Laviesta Ferrell.

7 **Q Can you spell the last name for the second**
8 **person?**

9 A F-E-R-R-E-L-L. Again, I'm not sure if they
10 actually have a transgender right now or not. I'm
11 asking Dr. Brady to coordinate that better so all
12 trainees have experience with transgender patients.

13 **Q Are you currently committed to treat**
14 **transgender patients at the Bingham Clinic?**

15 A As we speak right now, yes.

16 **Q Is it true that all patients who come in to**
17 **the Bingham Clinic who are LGBT are generally referred**
18 **to Dr. Brady for treatment?**

19 A I -- I think that's fair to say. They go --
20 we have 30 -- 30 clinicians who work there. So she may
21 take the majority, but there is no set. They all go the
22 way -- one way or the other. We're, as I mentioned,
23 trying to coordinate that.

24 **Q Do you have any reason to believe that, if not**
25 **now, that there is going to be some change such that you**

1 **do not treat or evaluate transgender patients?**

2 MR. KOSTELNIK: Form.

3 A Let me think about your question. As we sit
4 here now, I have no reason to think there will be a
5 change in how we do things.

6 Q But do you -- as you sit here today, do you
7 have any reason to think that going forward, you will
8 not be treating transgender patients at Bingham Clinic?

9 A I said, as we sit here now, I don't know of
10 any plans to change things differently.

11 Q Since you've been at the Bingham Clinic, how
12 many of the 30 transgender patients have you diagnosed
13 as having gender dysphoria?

14 A Probably most of them.

15 Q So out of --

16 A And I say probably, because the -- there are
17 the three sites, the emergency room, the inpatient --
18 well, four sites, the inpatient and Buckhorn Treatment
19 Center and outpatient clinic. So the majority of them
20 would have gender dysphoria diagnoses.

21 Q Can you just briefly describe what is
22 inpatient and outpatient?

23 A Outpatient is where people come for an hour
24 session, they may come for an evaluation, when we do
25 assessment procedures. And inpatient is when their

1 functioning has deteriorated to the point where they can
2 no longer be in the community, no longer attend school.
3 So it's typically those individuals who evolve with
4 self-harm, aggression, suicidal behavior and so forth.
5 And then -- so those are the two main distinctions.

6 **Q Okay. And --**

7 A We would, in our system, see some on the
8 medical floors, occasionally, a diabetic child who is in
9 crisis, we discover they're transgender, but I don't,
10 personally, become involved with those cases.

11 **Q So out of the 30 transgender patients at**
12 **Bingham, how many have you evaluated, consulted with or**
13 **spoken to only in the context of the inpatient**
14 **treatment?**

15 A I was trying to think through that. I think
16 it's in the range of probably eight to ten.

17 **Q Okay. And what about outpatient?**

18 A Similar, eight to ten, and Buckhorn would be
19 12 to 14.

20 **Q When you did the -- oh, let me strike that.**
21 **For Buckhorn, do you actually go to the residential**
22 **facility?**

23 A Buckhorn treatment is done through a procedure
24 called telepsychiatry, because Buckhorn is a distance
25 from here. So the clinic is run every week through

1 electronic needs.

2 **Q Can you explain how that works?**

3 A Well, interestingly enough, it's not unlike an
4 office visit. The patient would come in, there is often
5 a nurse or a therapist there. I will interview with
6 respect to symptoms of the last week. The heaters that
7 have resulted from living on the unit, have contact with
8 their family, medication side effects, and then if there
9 is time, a general flow of their life and where they're
10 headed with that. Because I'm a consultant there, every
11 week I see them, but moment by moment I'm not with them
12 and I would advise and give direction to the therapist
13 who works with them every day. So that's, again, it's a
14 residential treatment type of situation.

15 **Q Okay. And what is -- for the transgender**
16 **patients that you've worked with at Buckhorn, how many**
17 **times would you have seen them on this --**

18 A Typically, they stay four months. So 14 to 16
19 times.

20 **Q So that's -- how frequently is that?**

21 A Weekly.

22 **Q Okay. Thank you. And you said in these**
23 **sessions, there is always a nurse there?**

24 A Usually. Nurse or therapist.

25 **Q Okay.**

1 A One -- one or both.

2 Q And out of those 12 to 14 transgender patients
3 at Buckhorn, did anyone wish to transition?

4 A Several of them have identified. Again, some
5 of these children are fairly young, 13 to 14, and plan
6 to transition. Yeah.

7 Q Did you help any of them with that process?

8 MR. KOSTELNIK: Form.

9 A We would talk about it. I made no effort to
10 change their mind, but wanted to understand their
11 decision-making process and how this was going to help
12 them and what their understanding was about helping
13 them.

14 Q Did any of them go on to receive puberty
15 blockers or hormone therapy?

16 A Not at Buckhorn. Outpatient appointments were
17 made for several of them as they were leaving, at a
18 medical facility, Buckhorn is not too far from
19 Cincinnati, so several of them were going to go up there
20 for those kinds of interventions.

21 Q They were going to go to an outpatient
22 facility in Cincinnati?

23 A Yes.

24 Q Okay. Which one or is there -- were there
25 multiple ones?

1 A Well, it's University of Cincinnati and it
2 would have been the -- I believe they have a gender
3 clinic. Our social worker staff would have arranged
4 that.

5 Q Okay. So you did refer --

6 A And I encouraged that. Yeah.

7 Q Okay. And the -- I'm assuming, and correct
8 me if I'm wrong, but the gender clinic in Cincinnati
9 would be the kind of innovative clinic that would
10 provide hormone therapy?

11 A Right. Right.

12 Q The eight to ten patients that you saw for the
13 inpatient hour session, did any of those patients go on
14 to transition gender?

15 A I'm sorry. The eight to ten patients where?

16 Q That you saw in the inpatient, one-hour
17 sessions?

18 A Oh, the inpatient service is a very brief.
19 Buckhorn we have them for four months, inpatient service
20 is very brief. Several I think had plans to do that,
21 but they were in the early stages of that, really.
22 Several were getting referred to our endocrine clinic.
23 Yeah.

24 Q Okay. So when you say endocrine clinic, is
25 that the same thing as using the word -- the phrase

1 gender clinic?

2 A Yes. Yes.

3 Q Okay. So I'm going to refer to that clinic as
4 a gender clinic.

5 A Sure.

6 Q At U of L.

7 A That's fair. That will do.

8 Q Okay. Okay. So the -- is it true then that
9 the eight to ten patients who wanted to transition were
10 actually referred over to the gender clinic at U of L?

11 A See, you've got to realize, not all -- it's a
12 transition. Not all of them were firm about where they
13 were headed. Some were involved with therapy. Some
14 were probably going to desist. I didn't know exactly
15 what happened with them and -- of the eight to ten of
16 the inpatient unit.

17 Q So you don't know -- so basically you don't
18 know the outcome of what happened to those eight to ten
19 --

20 A That's correct.

21 Q -- people, right?

22 A That's correct.

23 Q Okay.

24 A Because they were there for other serious
25 psychiatric problems, which is consistent with the

1 literature of all these transgender adolescents and it's
2 growing.

3 Q So what happens, generally, when people go in
4 for the inpatient, one-hour assessment? Is that the
5 person --

6 A Well, inpatient is a 24-hour observation
7 assessment, inpatient. Outpatient is the one hour.

8 MR. KOSTELNIK: Try to let her finish the
9 question before you respond, just for the court
10 reporter's sanity.

11 MS. NARDECCHIA: Yes. Yeah.

12 BY MS. NARDECCHIA:

13 Q I know you probably know where I'm going, but
14 just let me say it.

15 A I'm sorry.

16 Q That's okay. Wait. So I'm confused. I
17 thought you said inpatient was the one-hour --

18 A No.

19 Q Okay. So outpatient is the one-hour
20 assessment?

21 A Yeah.

22 Q Sorry. Yeah. That makes sense. So do you
23 know the outcome of the eight to ten transgender
24 patients that you have seen for inpatient?

25 A No. No.

1 Q Since you came to Bingham Clinic, 2003, have
2 you ever had your own private consulting or therapy
3 practice?

4 A No. It's not allowed.

5 Q Do you have a business? Like a corporation
6 that you use for your work as an expert witness?

7 A No. Just as a -- what's called a sole
8 proprietor. I do it and it's just me.

9 Q Can you tell me -- well, strike that. Have
10 you, yourself, ever prescribed puberty suppressing
11 hormones for any patient?

12 A No.

13 Q Ever refused to do that when a patient asked
14 you to?

15 A No.

16 Q Do you oppose puberty blockers for all gender
17 dysphoria adolescents?

18 A No.

19 Q Can you explain what are considered the
20 justifications or reasons for puberty blockade to be
21 used?

22 MR. KOSTELNIK: Form.

23 A Well, the justification or the rationale is
24 that these individuals are distressed by their bodily
25 functioning. They're distressed by the expression of

1 their genetic sex and to have that blocked gives some
2 resolution to that distress. The idea is I no longer
3 have to look at the fact I'm becoming female, that is
4 blocked. It's also said by many that this allows
5 adolescents the ability to buy time so they can kind of
6 sort out what the future will be. Time where they're
7 not bothered by the impending signals of puberty hormone
8 change and so forth.

9 **Q And how did you come to know those reasons for**
10 **puberty blockade?**

11 A Research and talking with colleagues.

12 **Q And that's part of WPATH's guidance, correct?**

13 A Their -- it's all over the place. It wasn't
14 WPATH necessarily, but

15 **Q Endocrine Society, also?**

16 A Psychiatry papers, endocrine papers,
17 guidelines. Yeah. These are now the standard ideas in
18 the field.

19 **Q And you don't disagree with them?**

20 A I have certain issues with many of them. Yeah.

21 **Q What are your certain issues?**

22 A Well, I think -- puberty blockade is often
23 associated with reversibility. The idea where you block
24 it and then you start up again. I think that it doesn't
25 do justice to the complexity of human development. If

1 you took four years away from a child in their
2 experience and then want to start up again, let's say,
3 we don't know what the implications of that. Again, the
4 phrase I used earlier unsettled science is all over the
5 place in this -- and so that, "Okay, I want to start up
6 again, what are the implications of that?" That's one
7 aspect. The increasing lowering age of doing this is
8 another. Again, what we've talked about already is when
9 do children decide, when are they able to decide, when
10 cognitively can they make a decision about some of these
11 aspects. So these are things that are being worked out.
12 Now, in a simple case that's crystal clear and the
13 parents have support, we need to recognize parents give
14 permission for all these things, kids are doing this and
15 it should be done if the parents want it done, but

16 **Q Yeah. Because if it's not -- it's not the --**
17 **so a child's -- all right. Well, let's strike that.**
18 **With puberty blockers, in particular, that starts on the**
19 **onset of puberty, correct?**

20 **A** It doesn't have to. I think it's simplest if
21 you do that and prevent any vestige of puberty from even
22 starting, but that would mean very, very young kids.

23 **Q Well, what age did you usually go through**
24 **puberty?**

25 **MR. KOSTELNIK: Form. Form.**

1 A Typically girls are earlier, begins at 9 to
2 10, Boys maybe 10 to 11, and then continues through the
3 process where an individual is able to create human
4 life, and that's typically seen as the maturation of
5 puberty.

6 **Q There is medical literature out there, though,**
7 **that puberty blockade is reversible, correct?**

8 A Oh, yeah. No. What I was talking about is
9 human development psychology that, yeah, if you block it
10 and then remove the blockade, it'll start up again, for
11 the most part. Although sometimes it doesn't and we
12 don't know, which cases are the ones that start up and
13 the ones that aren't. That's still like so much of
14 this, unsettled.

15 **Q Your opinion is not that puberty blockade**
16 **eliminates puberty though, right?**

17 A No. No. It eliminates some of the early
18 manifestations of it, but -- and puberty and adolescents
19 are two different terms. It doesn't eliminate
20 adolescents. It eliminates some aspects of puberty, but
21 they will be picked up later at some point.

22 **Q Right. For instance, if someone does cross**
23 **sex hormone therapy, correct? They will go through**
24 **puberty?**

25 A Yeah. I guess. I'm not an endocrinologist,

1 but they would go through some physical changes
2 associated with the cross-sex hormones that they got.

3 **Q And are you aware of the study -- a 2014 study**
4 **by Annelou de Vries and others that's entitled, "Young**
5 **Adult Psychological Outcome after Puberty Suppression**
6 **and Gender Reassignment."**

7 A Where was that published?

8 **Q Let me see. That's Pediatrics, the official**
9 **journal of the American Academy --**

10 A Right. And what month there?

11 MS. ALTMAN: I don't think she got to finish
12 the title, just to keep the record clear.

13 **Q Yeah. Just let me -- The American Academy of**
14 **Pediatrics. It was in -- published online September 8,**
15 **2014.**

16 A Right. I'm familiar with that, as in most of
17 these studies, I don't have all the details at my
18 fingertips. But I am familiar with certain aspects of
19 that, that after one year, the outcome look fairly
20 positive. What's usually important in that study is
21 that the patient population had essentially no
22 psychiatric problems. They were a "clean group," to use
23 that phrase. And so they were highly selected and
24 predisposed to do better. The groups that I've talked
25 about, in terms of my own practice, that's coming out in

1 a number of other literature, these are much, to use a
2 lay phrase, "messier groups." But I'm aware of that
3 study and that there was a relatively positive outcome
4 after one year.

5 **Q Okay. And the conclusions of that study were**
6 **that a clinical protocol that included puberty**
7 **suppression followed by cross sex hormones and gender**
8 **reassignment surgery provided gender dysphoria youth**
9 **with the opportunity to develop into well-functioning**
10 **young adults.**

11 A Yes.

12 **Q Would you agree?**

13 A Yes. That was a conclusion and in that group,
14 that seemed to be the finding. Yes.

15 **Q But you don't think that finding translates to**
16 **other gender dysphoria youth?**

17 A Oh, absolutely not all of them. But I think
18 if you select various groups, there is another factor
19 here too, the longer-term outcome, there are studies of
20 transgender, sex reassignment, individuals like after 30
21 years they look at lot different. So after one year,
22 that was a good study. On the other hand, it depends on
23 the patient population, and this population was very
24 well chosen and a very -- fairly stable group of kids,
25 basically.

1 Q But you don't doubt -- you don't question the
2 results; is that right?

3 A No. No. And they exist, and those kids exist
4 out there and that's -- those are the ones that should
5 get it if -- and be part of that.

6 Q Okay. Have you ever prescribed hormone
7 therapy for any patients that you've diagnosed with
8 gender dysphoria?

9 A No.

10 Q Or any patients at all? Sorry.

11 A No.

12 Q Has the -- one of your patients ever asked you
13 for that?

14 A No. Again, that would be the endocrine
15 clinic, really, that would get that request.

16 Q Do you -- sorry if I asked you this before, I
17 can't remember. Did -- have any of the 30 transgender
18 patients you've interacted with at Bingham actually gone
19 on to receive hormone therapy by going to a gender
20 clinic?

21 A Well, I'm sure there have. When you say
22 Bingham Clinic, that does include the three sites I
23 mentioned. I know, for a fact the one young woman did
24 go to Cincinnati and began transitioning and I know
25 there are others. But I haven't followed up on what

1 happened to them.

2 **Q Have you kept in touch with that patient that**
3 **went to the gender clinic in Cincinnati and --**

4 A No. No. I don't stay in touch with any of
5 the ones really at Buckhorn. Although we have two now
6 coming to our clinic here. I encourage good follow up
7 for their psychiatric needs and so the ones in
8 Louisville, sometimes they'll come to our clinic. Yeah.

9 MR. KOSTELNIK: Do you need a break?

10 THE WITNESS: I'm doing fine.

11 MS. NARDECCHIA: Sorry. Do you want to go off?

12 MR. KOSTELNIK: Yeah. Why don't we just take a
13 little bit of a break.

14 MS. NARDECCHIA: Yeah. We'll go off the
15 record.

16 (OFF THE RECORD)

17 VIDEOGRAPHER: It is 2:02 and we are back on
18 the record.

19 BY MS. NARDECCHIA:

20 **Q Would you agree with me that there has been**
21 **controlled research showing that gender affirming**
22 **treatment alleviates distress associated with gender**
23 **dysphoria?**

24 MR. KOSTELNIK: Form.

25 A That research is beginning to be done. There

1 have been a couple of studies that have indicated that.
2 And they're methodologic problems with them and there is
3 really no -- much follow up beyond six, nine months. So
4 we'll just have to wait and see how long it lasts, but
5 certainly affirming a child helps and taking that stress
6 of dealing with this discordance is initially something
7 that kids feel good about.

8 **Q When there is no -- well, do you agree with me**
9 **that it would be unethical to do a control study with**
10 **one group receiving gender affirming treatment that's**
11 **been shown to work and the other group not?**

12 MR. KOSTELNIK: Form.

13 A It would be hard to get a study like that
14 approved and that's the point I made earlier about
15 bathrooms. This is the way science does it. You need
16 to have a controlled trial initially, but to just do it
17 and see if it works, then it -- you're kind of stuck and
18 if it seems to work, you don't know why it's worked, but
19 you could never have another study withholding that from
20 somebody. So but I'm aware of those studies and they're
21 --

22 **Q And the reason that you wouldn't give one**
23 **group the treatment that's been shown to be effective,**
24 **at least by some studies, is that -- could put those**
25 **people not receiving the treatment at increased risk --**

1 A Well, that's the theory. I don't think it
2 would, but that's the theory, and the studies that have
3 been done so far, they are -- I don't know if you want
4 to get into -- it's probably not worth it to get into
5 methodologic problems, but one of them in particular,
6 the parents were the ones who were the raiders, which
7 would really not pass muster in any eight-grade science
8 course.

9 **Q Which study are you referring to?**

10 A The study by Olson in Pediatrics. So but I'm
11 aware of that and certainly the data are what they are,
12 they feel better.

13 **Q Okay. This is -- hold on, let me just find.**
14 **This is the study by Kristina Olson entitled, "Mental**
15 **Health Transgender Children Who are Supported in their**
16 **Identities"?**

17 A Yes.

18 **Q Okay. And didn't that study conclude that**
19 **socially transitioned transgender children who are**
20 **supported in their gender identity have better mental**
21 **health outcomes?**

22 A That's what it found and that's my point. That
23 was determined by what the parents said and only after
24 six or nine months follow up. And there is another
25 aspect to that and -- I need some guidance here how much

1 further I go. Is this for later on?

2 MR. KOSTELNIK: I can't assist you in
3 answering.

4 A Okay. Well, I'll just say it that one needs
5 to liken it to if you struggle with something, it's very
6 difficult like calculus, and then the teacher says,
7 "Kids, the calculus is cancelled. The class is
8 cancelled, the exam is cancelled, and you no longer have
9 to do it." The initial response will be euphoria,
10 that's terrific, great. Later on the questions will
11 sort out, "Maybe calculus is something I should grapple
12 with and master." But the -- so the fact that there is
13 an early response to affirming something that the
14 children are anxious about, yeah, of course.

15 Q But if children are supported in their --

16 A And children should be supported.

17 Q -- in their gender identity, let me just ask
18 my question, okay? You're jumping in. Okay. so I know
19 you don't quite agree with it, but the DSM-5 and other
20 standards of care do say that consistence, insistence,
21 persistence, even by children, and adolescents is one of
22 the diagnostic criteria for gender dysphoria, right?

23 MR. KOSTELNIK: Form.

24 A DSM does not say that.

25 Q It doesn't say that?

1 A You'll see it published or written in articles
2 including Dr. Olson, but it's not in the DSM-5.

3 Q Okay.

4 A As a criteria.

5 Q Well, let me look that up in just a minute.
6 But if a child is affirmed early on in their identity
7 and they can avoid having to go through gender dysphoria
8 and the distress that is accompanies, isn't that a good
9 thing?

10 MR. KOSTELNIK: Form.

11 A No.

12 Q It's not a good thing. Okay. So you'd rather
13 the child endure a gender dysphoria and all the distress
14 that it comes with that with the feeling that their body
15 -- they're not in the right body. You'd rather have
16 them go through that and not be affirmed early? You
17 think that that's just a normal challenge that a child
18 has to endure?

19 MR. KOSTELNIK: Form.

20 A Well, it's certainly not a normal challenge
21 because it's very unique, but the fact that it's
22 distressing should not prevent any child or family, for
23 that matter, from pushing through and dealing with the
24 distressing. It is part of normal development and part
25 of what makes people healthy. And so to shy away from

1 something that's distressing is typically not effective
2 parenting.

3 Q Well, it's not distressing like a calculus
4 test, right? It's actually a diagnosis in DSM-5, gender
5 dysphoria, it's not the same thing, right?

6 MR. KOSTELNIK: Form.

7 A Oh, yeah. Analogies are never the same thing
8 as the real thing, but, yeah.

9 Q Why would you prefer for a child to not
10 receive gender affirming treatment and to deal with
11 experiencing gender dysphoria rather than being affirmed
12 like the parents in the study by Kristina Olson?

13 MR. KOSTELNIK: Form.

14 A I want this child to be affirmed. I want the
15 families to be affirmed. I want children to deal with
16 reality.

17 Q When you say affirmed, what do you mean? You
18 don't mean gender affirming treatment, right?

19 A Yeah. I agree that it gets -- because that
20 word is now becoming not helpful, because it's used
21 solely in the context of affirming gender, but every
22 child in a family needs to be cared for, supported and
23 in that sense, affirmed. But for a boy to say he's a
24 girl, a genetic boy to say he's a girl, this is not true
25 and an inaccurate idea. Now, a child should be listened

1 to. In the rare number of kids who somehow and some
2 unknown way, we have biology that predicts a course to
3 our transgender, eventually, you could affirm them, but
4 not -- not very early.

5 **Q When can you affirm them, what age?**

6 A Well, you need to work through adolescence and
7 you get to -- get to be adulthood and say I don't -- you
8 know, I don't belong here.

9 **Q Wait. So you can't affirm someone's gender
10 identity they're expressing until adulthood?**

11 A You can. But I think we don't have criteria.
12 We don't know when. We don't know how. Which ones are
13 going to desist? They're all kinds of questions that
14 makes this difficult. And of course, there is a
15 tremendous push to do, because to do this, because if
16 you don't do it then it's too late and that's why this
17 is such a complicated --

18 **Q So is it your opinion that no one should be
19 affirmed in their gender identity until they reach
20 adulthood?**

21 A No. I wouldn't say that. I would just say we
22 need to do research to clarify which kids are going to
23 be on the path that are obvious transgenders and which
24 one is not. We need to try to delineate that better.

25 **Q What reality do you want the children who are**

1 **expressing a cross gender identity to have to deal with?**

2 MR. KOSTELNIK: Form.

3 Q You mentioned they got to deal with reality.

4 A The biological reality of their sex.

5 Q Okay. Don't both genders have male, female,
6 there is expectations of both, right? Of --

7 A Sure.

8 Q -- boys, they're supposed to be a certain way,
9 girls are supposed to be a certain way, right?

10 MR. KOSTELNIK: Form.

11 A And there is a vast range of that. Yeah.
12 Yeah.

13 Q so why would transitioning from the role, the
14 expectations of one gender to another be any easier when
15 there is expectations of both?

16 MR. KOSTELNIK: Form.

17 A Yeah. I -- with -- with effective parenting
18 the sex of either child is guided toward adjustment in
19 our culture and society. That's what we call gender.
20 Gender expectations. And many of the children who
21 choose or adopt or feel they are of the other gender
22 have trouble accepting, dealing, not wanting with. And
23 they express that with distress.

24 Q Has any person, any transgender patient, ever
25 told you that they are transgender, because they don't

1 want to deal with the expectations of their sex?

2 A Of course not. No.

3 Q Okay.

4 A Just because most -- most psychiatric patients
5 don't describe their symptoms in that way. Until they
6 take time to sort through and disentangle what caused
7 everything. How it all fits together.

8 MS. NARDECCHIA: So move to strike
9 everything after the response to the question.

10 Q So let's just try this again. Yes or no, has
11 any person ever told you that they are transgender,
12 because they're trying to avoid the expectations of
13 their sex assigned at birth?

14 MR. KOSTELNIK: Object to form.

15 A Yeah. Not that way. No.

16 Q No. Okay. Are you aware of the 2012 report
17 by Robb Travers and others that showed that transgender
18 youth who have strong parental support for their gender
19 identity and expression report higher life satisfaction,
20 higher self-esteem, better mental health, including less
21 depression and fewer suicide attempts and adequate
22 housing compared to those without strong parental
23 support?

24 A And where was that published? Sometimes I
25 don't have the author's name in my mind.

1 Q Well, I can't --

2 A That sounds like a positive outcome, sure.

3 Q Are you familiar with that?

4 A I'd say no.

5 Q It's entitled, "Impacts of Strong Parental
6 Support for Trans youth."

7 A I think I've seen that, but the details of it
8 aren't, but...

9 Q Do you know of any report finding that
10 transgender youth benefit from a lack of strong parental
11 support?

12 A No.

13 Q So have you ever had any patient come back to
14 you as an adult and say, "I am transgender because I
15 wanted to escape the expectations that my birth sex put
16 upon me"?

17 MR. KOSTELNIK: Form.

18 Q Or words to that effect?

19 A No.

20 MR. KOSTELNIK: Form.

21 Q Has your treatment of any of the 60
22 transgender patients that you've talked about involved
23 prayer or pastoral counseling?

24 A No.

25 Q Have you ever referred any patients who are

1 transgender to anyone else who engages in prayer or
2 pastoral counseling?

3 A No.

4 Q Have you ever referred a patient to an
5 organization or entity that attempts to change people's
6 gender identity?

7 MR. KOSTELNIK: Form.

8 A No.

9 Q What about to change someone's sexual
10 orientation?

11 A No.

12 Q As -- are you currently CEO of Bingham Clinic?

13 A Yes.

14 Q And if there was a practice at the Bingham
15 Clinic that you thought was harmful to patients, would
16 you be obligated to report it to anyone?

17 A Yes.

18 Q Who would you be obligated to report it to?

19 A The chairman of pediatrics.

20 Q And that -- I'm sorry. Is that Dr. Woods?

21 A Yes.

22 Q Okay. What's the dean of the medical school's
23 name?

24 A Dr. Ganzel.

25 Q What's her first name?

1 A Her first name is Toni.

2 Q Is there a code of conduct -- (clears throat)
3 sorry -- code of conduct at U of L physicians that says
4 when you are faced with an ethical dilemma take action
5 and speak up?

6 A I believe that's part of the requirements.
7 Yeah.

8 Q So would you agree that if there were any
9 physician at Bingham Clinic or the University that you
10 thought were treating patients in a manner contrary to
11 standards of care, you'd be required to speak up about
12 that?

13 MR. KOSTELNIK: Form.

14 A You would speak up about that. Yes.

15 Q Do you -- strike that. Do physicians at U of
16 L have their own biography web pages?

17 A That's kind of undergoing transition. I think
18 there are brief statements about us on line, webpage.

19 Q Do you have one?

20 A I haven't looked at mine lately.

21 Q Did you create it?

22 A No. those things are created by the -- the
23 various departments and are fairly -- I think fairly
24 skimpy, actually. They don't provide a lot of
25 information, but

1 Q And you don't list -- or on your website, it
2 doesn't list LGBT Healthcare as an area of expertise or
3 interest for you, correct?

4 MR. KOSTELNIK: Form.

5 A Correct.

6 Q But it does for other people within the
7 Bingham Clinic, correct?

8 MR. KOSTELNIK: Form.

9 A Yes. I don't know how many, but

10 Q And there is some -- there is currently five
11 child and adolescent psychiatry professionals at U of L,
12 who identified themselves as LGBTQ friendly, and you're
13 not one of them, right?

14 MR. KOSTELNIK: Form.

15 A I was going to register and got ready to do
16 that recently but I was disallowed.

17 Q You were going to register for what? I'm
18 sorry.

19 A To post the rainbow sticker that people get at
20 U of L, if they are deemed LGBT supportive and friendly.
21 I was refused to be given one of those and so I chose
22 not to register for that online thing, because I knew
23 that would be kicked out as well.

24 Q Okay. Who denied your request for the -- to
25 register for the rainbow sticker indicating --

1 A Some -- some --

2 Q -- sorry. Just let me ask -- finish my
3 question. Indicating that you're LGBT friendly and
4 supportive?

5 A I believe his first name was Brian. He's the
6 office manager of the LGBT Center. He's not a doctor,
7 physician, this is, you know, and activist office on
8 campus. So as I have done more of this kind of activity
9 and others, people have felt I'm not worthy to do that
10 kind of work.

11 Q Okay. The -- you referred to the LGBT center
12 on U of L campus as an activist office?

13 A Well, that's one of the things they do and I
14 think they coordinate other activities in support of
15 LGBT students.

16 Q Okay. And it's your understanding that Brian
17 denied your request to have the rainbow sticker to show
18 your support of LGBT patients?

19 MR. KOSTELNIK: Form.

20 A Yes.

21 Q Okay. How did that come about?

22 A I have no idea.

23 Q Okay. Who are you referring to when you said,
24 "People have thought you were not worthy to do that kind
25 of work"?

1 A I'm just assuming. I -- I don't know. But I
2 didn't get the -- the rainbow sticker and so I chose --
3 that list say -- of the five people, I would have been
4 on that list, but I chose not to apply, because I
5 assumed that it may have a similar outcome as the
6 rainbow sticker.

7 **Q Let me mark this -- oh, yeah. Sorry. Let me**
8 **check that. You said, "Not worthy to do that kind of**
9 **work." What work was that?**

10 A Just clinical work with transgender patients.

11 **Q Has anyone expressed to you any concerns or**
12 **reservations about you performing clinical work with**
13 **transgender patients?**

14 A A couple of people have.

15 **Q Who?**

16 A Dr. Brady has. Actually, Dr. Brady is the
17 only one.

18 **Q Nobody else?**

19 A Not to me. No. They may have said something.

20 **Q Did you have a discussion with Dean Ganzel**
21 **about this?**

22 A No.

23 **Q Or anyone else besides Dr. Brady?**

24 A Around the -- these larger issues, of course,
25 I mentioned that my immediate superior is Dr. Woods and

1 I've talked with him several times about this.

2 **Q And what did -- can you tell me about that**
3 **discussion?**

4 A He encouraged me to review these matters with
5 our faculty and I've done a little bit of that with a
6 couple of people and plan to do it at our next meeting.

7 **Q Has anyone at U of L indicated, in any way,**
8 **that they are concerned with the opinions that you're**
9 **offering in this case?**

10 A Well, see, I don't think they know what
11 opinions I am offering. So I don't -- they seem to --
12 they seem to know more about this case than -- in some
13 ways, than I do.

14 **Q Has anyone talked to you about your**
15 **participation as an expert witness in any case regarding**
16 **transgender people?**

17 A Well, I've talked with -- with Dr. Woods about
18 this.

19 **Q Okay. Did Dr. Woods express any concern about**
20 **your participation as an expert witness regarding**
21 **transgender individuals?**

22 A He has affirmed my right as an academic to
23 speak my knowledge of the field. He's expressed concern
24 about the opinions of individuals in our division who
25 might differ in some ways from my positions and the

1 division and divisiveness that this might add.

2 **Q Why do you say that Dr. Brady seems to know**
3 **more than you do or more about this case?**

4 A Well, just the nature and the depth of your
5 questions just has that feel? I have no evidence, what
6 --

7 **Q When you talked to Dr. Brady about the**
8 **concerns she had about your clinical work with**
9 **transgender patients, can you tell me what she said?**

10 A She said she didn't trust me.

11 **Q To work with transgender patients?**

12 A Correct.

13 **Q Did she elaborate why?**

14 A No. And -- that's why I have no idea.

15 **Q Did you ask her?**

16 A She declined to comment further. I think I --
17 I raised my eyebrows or something. I had 40 years'
18 experience, she has two. I -- I just didn't understand
19 what she was coming from.

20 **Q You recently gave a speech at the Heritage**
21 **Foundation, correct?**

22 A I was part of a panel where I spoke for ten
23 minutes, if you refer to that as a speech.

24 **Q Yeah. A panel with Dr. Hruz and Dr. Cretella,**
25 **correct?**

1 A Correct.

2 Q Yeah. Did you tell anyone at U of L, that you
3 were going to be doing that panel before you did it?

4 A No more so than what I mentioned earlier,
5 three years ago, as I began to do this kind of
6 consultation, being aware of the divisive nature of it,
7 but each and every case that I've been involved with I
8 didn't go report that and nor did I report that panel
9 that I was involved with at the Heritage Foundation.

10 Q Did anyone at U of L express to you that they
11 had concerns or disagreement with the views you
12 expressed during your Heritage panel -- Heritage
13 Foundation Panel?

14 MR. KOSTELNIK: Form.

15 A Several people did and I had a bunch who
16 enjoyed it thoroughly.

17 Q Who were the people who expressed concerns?

18 A Well, Dr. Brady, Dr. Carter, Dr. Stocker,
19 would be three names that come to mind.

20 Q I'm sorry. The -- I missed the second one.

21 A Dr. Carter and Dr. Stocker.

22 Q Stocker?

23 A Yes.

24 Q Are -- what does Dr. Carter specialize in?

25 A He's a psychologist who specializes in the

1 psychological problems in medically ill children.

2 **Q Okay. What about Dr. Stocker?**

3 A Dr. Stocker is an outpatient child
4 psychiatrist.

5 **Q Who were the people who enjoyed your Heritage
6 Foundation panel thoroughly?**

7 A Robert Caudill, Scott Hedges, Sheri Black,
8 Drion Bibb, Stanley, I'm blocking on his last name,
9 these are people in and/or outside of Louisville, too.

10 **Q Do any of those -- I counted five people, work
11 at U of L?**

12 A Yes.

13 **Q Which ones?**

14 A Caudill, Hedges, Bibb used to, he just left,
15 and Sheri Black used to, and she just left as well. She
16 was a board member. I've had e-mails nationally from
17 colleagues, doctors. Some people I knew; some I didn't
18 know, who said the views expressed resonate with them.

19 **Q Do any of those five people you said
20 thoroughly enjoyed it, are any of them doctors who treat
21 transgender patients?**

22 A Yes.

23 **Q Which ones?**

24 A Caudill and Hedges and several from outside
25 the center as well.

1 Q What is Robert Caudill's expertise?

2 A He's an adult psychiatrist.

3 Q And what about Scott Hedges?

4 A Is it possible to ask why -- why this is
5 relevant? I'm going to guess not.

6 MR. KOSTELNIK: You have to respond.

7 A I'll just answer it. I'll just answer your
8 questions.

9 Q Yeah. What does --

10 A So what was --

11 Q -- Scott Hedges -- Scott Hedges, what does he
12 do?

13 A He's a psychiatrist who directs our programs
14 at one of the community mental health centers. He's a
15 medical director of that program. Dr. Caudill, he's a
16 director of training in psychiatry. And you mentioned
17 the others were people who have supported our clinic in
18 different ways who are non-physicians. And then some of
19 the other people outside, a neurologist from Florida e-
20 mailed me. A psychiatrist from Wisconsin e-mailed me. I
21 mean, I can give you all the names.

22 Q I'm just asking about U of L right now.

23 A Okay.

24 Q Yeah.

25 A Right. But those would be the ones at -- in U

1 of L network.

2 **Q Caudell and Hedges, they do not treat**
3 **transgender children or adolescents, correct?**

4 MR. KOSTELNIK: Form.

5 A They're both adult psychiatrist, so I don't
6 know. I doubt very much. Although Hedges administrates
7 a clinic where this comes up all the time, so

8 **Q What were the concerns expressed by Dr. Stock**
9 **(sic)?**

10 A Stocker?

11 **Q Stocker. Thank you.**

12 A His concern was very specific, because the
13 panel at the Heritage Foundation was publicized widely
14 and one of the places where it was publicized was
15 apparently on a Breitbart news site and Dr. Stocker, I
16 suppose, the lay phrase would be, "went ballistic,"
17 because he's a very political guy and he doesn't like
18 that website. So that was essentially the nature of his
19 argument.

20 **Q Was he upset that you identified yourself as**
21 **being with the Bingham Clinic?**

22 MR. KOSTELNIK: Form.

23 A I think he was not the only one, and I did not
24 identify myself. I made every effort not to. It was
25 announced by the coordinator of the panel that I spoke

1 for myself, but these things get publicized and written
2 in ways that -- I think that bothered him. Yes.
3 Although, I assured him that it was out of my control.

4 **Q But somebody during that panel, you were**
5 **identified, either by someone else or yourself as being**
6 **at the Bingham Clinic; is that right?**

7 A Actually, no. I was identified as being with
8 the University of Louisville, but the Bingham Clinic was
9 not mentioned.

10 **Q Did you identify yourself as being with the**
11 **University of Louisville?**

12 A The coordinator of the program identified
13 myself. I did not.

14 **Q Okay.**

15 **And what were Dr. Carter's concerns about your**
16 **Heritage Foundation panel?**

17 A He was concerned it was going to affect his
18 recruitment of his psychology intern.

19 **Q Did he expand on that?**

20 A Not really. We -- we did this in a public
21 meeting so it was difficult to.

22 **Q Was it a public meeting?**

23 A In one of our faculty meetings, several of
24 these issues came up with Brady, Carter and Stocker.

25 **Q Who else was at the faculty meeting besides**

1 **yourself and those three?**

2 A Well, really the rest of our child psychiatry
3 faculty, except for Dr. Peters and Dr. Lohr. But
4 everyone else was there. And we have a group of 11
5 individuals. I can give you names.

6 **Q That's okay. It was everyone from your**
7 **department?**

8 A Right.

9 **Q Okay. Did anyone express during that faculty**
10 **meeting that the views you expressed in the Heritage**
11 **Foundation video were -- did not jive with the views of**
12 **other people working at The Bingham Clinic?**

13 MR. KOSTELNIK: Form.

14 A Interesting enough, that wasn't the thrust.
15 Dr. Carter and Dr. Brady had other concerns about my
16 behavior as their immediate chief related to making that
17 precedent. But there weren't comments on the
18 presentation itself. Dr. Carter was -- Dr. Stocker was
19 concerned that it had been quoted by this new site. One
20 other faculty was concerned about just how this looks
21 for the division with me being the leader of the
22 division.

23 **Q Who said that?**

24 A Dr. Jennifer Le, I think expressed something
25 like that.

1 **Q What were the other concerns? You mentioned**
2 **they had other concerns, other than the Heritage**
3 **Foundation panel in that meeting.**

4 A Oh, a number of things were brought up. One,
5 was how relationships with pediatric endocrinology, how
6 I handled negotiating increased time with the oncology
7 clinic for -- for Dr. Brady. Just a laundry list of
8 things of just piling on, to use that light phrase.

9 **Q What was the problem with the relationship**
10 **with the pediatric endocrinology?**

11 A No. Oncology.

12 **Q Oh, oncology.**

13 A Well, there was -- there were two clinics,
14 oncology -- really, they were upset about some
15 miscommunication and, I think, endocrinology, some of
16 the faculty there disagreed with my -- my views.

17 **Q What was the miscommunication?**

18 A The chief of pediatric oncology wanted more
19 time, child psychology consulting time, from Dr. Brady.
20 I said, "Fine." He came back and said, "I don't know if
21 we have the money." I said, "Fine." Then apparently,
22 he said he did have the money. I hadn't heard about
23 that. Somehow didn't get back to me. And Dr. Carter
24 and Dr. Brady were upset. And I rectified that after
25 that meeting and it took me ten minutes to fix it.

1 Q Okay. And what was the endocrinology
2 disagreement with your views?

3 A I don't know. They just expressed that they
4 were upset with me.

5 Q Who told you that?

6 A Dr. Carter.

7 Q And you didn't ask what -- why was
8 endocrinology upset with your views?

9 A This was a public meeting. It was not the
10 time or place.

11 Q Do you know who in endocrinology disagreed
12 with your views?

13 A Probably Dr. Wintergerst and Dr. Kingery. But
14 again, I -- this is speculation. I don't know. And it
15 wasn't brought up to me and --

16 Q You have no idea what views they had a
17 disagreement with you on?

18 A See, I don't think they know. I don't think
19 people really understand my views, apart from the brief
20 public panel that was available online.

21 Q So...

22 A No one has actually listened to me.

23 Q Okay. So it's your views with regard to
24 transgender patients?

25 A Yeah. Yeah. And my view is quite simple, if

1 they would just ask me.

2 Q Have you ever worked with Dr. Kingery?

3 A No.

4 Q What is your view that is easy for transgender
5 patients?

6 A Are you serious?

7 Q Yeah. No. I --

8 A I'll try to be brief. So that children are
9 born one of two types of human beings. In the rare
10 instance, there can be disorders of sexual development,
11 but infidcently small number. And it's clearly seen
12 as a medical disorder. Children develop gender through
13 an interaction of their biologic predisposition and
14 interacting with parents in the environment where they
15 learn what it means to be a little boy and a little
16 girl. For some kids, and we don't know how many, they
17 appear to adopt the other viewpoint. But these things
18 are in the range of temperament and biological nature
19 and predisposition. And when parents are clear and
20 supportive, kids can be brought toward the alignment
21 with genetic sex. As then they move to adolescence, a
22 number of others adopt this disposition, that I'm born
23 in the wrong body or that I have discomfort with my
24 biological sex. And in some of those cases, like the
25 pediatric study you referred to, with appropriate

1 treatment and biological change, they can do quite well.
2 What appears for the vast majority of patients, these
3 symptoms occur in the middle of manifest cycle
4 pathology. Depression, anxiety, family dysfunction,
5 substance abuse, chaos of one kind or another in the
6 desperate desire not to be female or male. And in those
7 situations, one needs to be patient and listen. And
8 there are increasing clinic reports for those who have
9 enough nerve to speak up to say, "I'm glad I came to a
10 therapist who was willing to ask me the tough
11 questions." And in some of those then they can just
12 sort out and realize I didn't have a gender problem in
13 the first place. But you get to that point by doing
14 basic psychiatry. Some kids, I mean, if it's straight
15 forward and it's just a gender issue, I believe they're
16 a rare number, maybe facilitate transition. But this is
17 far more complex than coming and asking -- and I think
18 Drew is a case and example. He wasn't doing real well,
19 he attempted suicide, a dysfunctional relationships, and
20 then fairly quickly after that identifies as
21 transgender, who knows. Who knows. But that would be a
22 rough -- rough summary of -- of how I would see this.
23 And actually, approaching that, I fit in with the
24 guidelines, all the guidelines that are published as I
25 said. They are not black and white. There are so many

1 things of good care that I do, that they do.

2 Q Well, I don't think any of the standards of
3 care would advocate to try to turn someone around in
4 their gender identity?

5 MR. KOSTELNIK: Form.

6 Q Do you -- don't you agree?

7 A I don't try to turn them right. I do good
8 psychiatry. And in the process, if they -- and even
9 that phrase. I mean, what phrases can one use these
10 days? That they determine -- and there are adults who
11 have done this. There are adults who after sex
12 reassignment surgery have felt they made a mistake. So
13 it's -- it's a tricky business.

14 Q Do you assume that it is better generally for
15 people to be cisgender, than transgender?

16 MR. KOSTELNIK: Form.

17 A Well, it's not whether it's better. It's --
18 it's more than norm. However, as our families are more
19 and more dysfunctional, we'll see less cisgender
20 probably.

21 Q Then what is the basis for your approach to
22 try to, if a child says -- if a child is born and
23 assigned male, says, "I am a girl." If it's not better
24 to be transgender or cisgender, then why would you try
25 to force that child to be cisgender, instead of letting

1 **them be transgender?**

2 MR. KOSTELNIK: Form.

3 A I wouldn't say better. I mean, it's -- it's
4 -- it's more natural. It's the fact, they are male or
5 female. And -- and by the way, sex is not assigned at
6 birth. It's identified and recognized.

7 **Q So you say "more natural". What is that based**
8 **on?**

9 A Science and hundreds of years of observation
10 of the human condition and development.

11 **Q Do you think transgender people are all**
12 **unnatural?**

13 MR. KOSTELNIK: Form.

14 A To -- well, I'm using too many words here.
15 You're not here for a seminar on developmental
16 psychopathology. Yes.

17 **Q And you mentioned earlier, -- well, let me**
18 **strike that. Is it your opinion that there will be more**
19 **transgender individuals in the population because of an**
20 **increasing -- increase in "dysfunctional families?"**

21 A You know, it's more complicated than that.
22 It's not just dysfunctional families, but when they're
23 less and less role models of a particular sex, when
24 those role models are fluid and they change one day or
25 one month to another, when there's not consistent --

1 actually, we'll come back to dysfunctional families.
2 When it's not a consistent regular relationship with an
3 adult figure who gives feedback to the child about
4 what's true and what -- then they're much more open to
5 really one way or another, and not having any firm, kind
6 of direction for the future.

7 Q Going back, The Heritage Foundation panel,
8 that was recorded, right?

9 A Yes.

10 Q Have you had a chance to watch the recording?

11 A Yeah.

12 Q How did you access it? On YouTube or
13 something?

14 A Yeah. Well, not YouTube. I think it's on --
15 Heritage has it on their own website.

16 Q And that's how you watched it?

17 A Yes.

18 Q Would you agree that you can have a
19 transgender child in a home that is "functional and
20 stable?"

21 A Yes.

22 Q And would you agree that not all people who
23 are transgender suffer from gender dysphoria?

24 A Yes.

25 Q And that it can be -- gender dysphoria can be

1 **alleviated through proper medical treatment, correct?**

2 MR. KOSTELNIK: Form.

3 A Proper treatment can include both
4 psychological and medical aspects. Yes.

5 Q You mentioned in your report -- sorry, I'm
6 going back to your work at the Bingham Clinic now.
7 Sorry, just give me a second. Okay. You mentioned in
8 your report that you, "supervised 26 clinicians at the
9 clinic and provide care for children, adolescents, and
10 families in a broad range of psychopathological
11 conditions, including gender dysphoria;" is that
12 correct?

13 A Yes.

14 Q What specifically do you do to supervise any
15 clinicians who treat for gender dysphoria?

16 A Well, I don't directly supervise that aspect
17 specifically in each case. My role is -- and, of
18 course, these are all licensed practitioners of varying
19 degrees of experience. And I get brought the difficult
20 situations that have to do with multiple medical
21 services being involved, legal services being involved,
22 dysfunctional families of one kind or another, and --
23 and some transgender. But my role is more consultation
24 and guidance, and not supervision per se. We do
25 supervise trainees or students who are in educational

1 programs.

2 Q How many clinicians would you say treat
3 transgender patients -- sorry, let me start over. How
4 many of the clinicians at Bingham Clinic would you say
5 treat children and adolescents who are suffering from
6 gender dysphoria?

7 A I've asked Dr. Brady to coordinate that
8 activity and find out, but she hasn't done that yet.

9 Q She -- she's in charge of that area?

10 A Well, she's going to be, I think. It hasn't
11 been formalized. And with all the things that have gone
12 on, it's kind of on hold right now. But, I -- I would
13 just be guessing. I do know that they're more than me
14 and Dr. Brady and Dr. Peters that see them. I just
15 don't know how many.

16 Q So at the gender clinic, is it only Dr. Brady
17 from your department who works there?

18 A That's correct.

19 Q And Dr. Brady supports puberty blockers --

20 A Yes.

21 Q -- for patients there? She supports hormone
22 treatment for transgender patients?

23 A Yes, as do I.

24 Q And does she support or recommend surgical
25 intervention for patients there?

1 A She doesn't get that far, I think, because of
2 the fact we deal with adolescents and children. I mean,
3 I suspect if she worked with adults, she would be
4 supportive of it, but I don't know.

5 Q So at the gender clinic, have you ever tried
6 to prevent any gender affirming treatment to be provided
7 to transgender patients there?

8 A No.

9 You haven't reported those -- the puberty
10 blockade, hormone therapy, or any other gender affirming
11 treatment as being unethical or improper?

12 A Absolutely not.

13 Q And does the gender clinic follow the
14 standards of care set forth in -- by WPATH?

15 A We're just in discussions about that. I think
16 which ones to adopt. I think WPATH are really loaded
17 toward it's an adult organization. I think the American
18 Academy of Pediatrics, American Academy of Child and
19 Adolescent Psychiatry are the ones that are more focused
20 toward children, but, you know, you have five different
21 guidelines. I don't think anyone in the clinic would be
22 against WPATH, but we'll see.

23 Q But WPATH does have guidelines --

24 A Oh, yes.

25 Q -- with regard to children and adolescents,

1 correct?

2 A Yeah.

3 Q Okay. And does the gender clinic at UofL
4 follow the Endocrine Society guidelines, with regard to,
5 hormone treatment and puberty blockade?

6 A I mean, do they?

7 Q Yeah.

8 A I'm pretty sure they do. Yeah.

9 Q As a psychologist at the gender clinic, is Dr.
10 Brady bound by the American Psychological Association?

11 A I think all the psychologists would follow the
12 guidelines that dictates of their professional
13 organization. I don't know if they would be bound by
14 it. I don't think it's that type of statement. But all
15 would follow it, I think. Yeah.

16 Q Do you follow the -- well, which guidelines do
17 you in your practice follow?

18 A For the psychiatrist it would be the American
19 Academy of Child and Adolescent Psychiatry.

20 MR. KOSTELNIK: You doing okay?

21 THE WITNESS: Yeah.

22 MR. KOSTELNIK: Okay. Keep on trucking.

23 BY MS. NARDECCHIA:

24 Q What about the American Psychiatric
25 Association?

1 A Those guidelines, I think, are somewhat
2 similar, but it wouldn't be something that the child and
3 adolescence psychiatrist respond to particularly.

4 **Q Did the Bingham Clinic offer treatment geared**
5 **toward aligning natal sex with gender identity?**

6 A I would say no. It's -- no.

7 **Q Why not?**

8 A To the extent that that occurs, and it might,
9 it's all individualized. In other words, we do not see
10 that symptom isolated to the overall functioning of --
11 of a child and family. Now, that's where we differ from
12 pediatric endocrinology. We want to become male or
13 female, this is what we want. Give us the medications.
14 That's it. For a child and adolescent psychiatry, the
15 children and families are distressed. We may see more,
16 and I think we probably would, that the only level of
17 their distress is that they are male or female and we
18 want to change. But, more often than not, they come in
19 with depression, anxiety, school failure, relationship
20 problem, parental substance abuse, and so forth. "And
21 by the way, we also have identified our daughter feels
22 she is male." And so then we look at that and try to
23 disentangle that. So sometimes they really are three
24 root. Sometimes that issue kind of disappears.

25 **Q Which issue? Sorry.**

1 A The issue of I am male or female. As they
2 sort through the other problems, sometimes it
3 crystallizes. And not only am I convinced of this, I
4 want to have medical treatments. And then we would
5 refer to pediatric endocrinology. And then sometimes
6 it's still up in the air. And so we continue to treat
7 and talk about it and "Where are you at today with
8 that," so to speak.

9 **Q How many patients since you've been at Bingham**
10 **Clinic, have expressed to you a cross gender identify**
11 **and then just had that disappear?**

12 A I have one right now who's -- this may not be
13 a -- it may be an issue and then it -- it goes away.

14 **Q Where are you treating that person?**

15 A At the Bingham Clinic. I had several at
16 Buckhorn who were in similar categories. And it kind of
17 goes like this. They bring it up, you follow it, you
18 ask about it. It's very important for this and other
19 disorders to not take the symptom as the only thing you
20 talk about, so they have a couple of other sessions
21 where you actually don't talk about gender and come back
22 to it. And some will say, "Well, it's not an issue for
23 me right now. I'm not -- I know I'm not male or
24 female." So

25 **Q So you've had patients say -- express that**

1 they did have a cross gender identify and then later say
2 they don't?

3 A Yes.

4 Q And how many since you've been at Bingham?

5 A Well, one that I'm seeing right now. A number
6 at Buckhorn --

7 Q How many at Buckhorn?

8 A -- after four months. Three or four maybe.

9 Q Okay. What -- those records from the three to
10 four at Buckhorn, where would they be?

11 A Well, Buckhorn would have them.

12 Q Do you have any records for your treatment for
13 patients at Buckhorn at Bingham Clinic?

14 A We have rough notes and guidelines. Yeah.

15 Q Did you do anything to guide those three to
16 four people, and the one you're currently treating, to
17 accept their natal sex, to suggest to them that it would
18 be better for them to accept their natal sex instead of
19 transitioning?

20 MR. KOSTELNIK: Form.

21 Q Or words to that affect.

22 A Disguise or discuss, suggest, wonder about,
23 these are all processes of therapy. This is not like a
24 business deal. This is what I recommend. This is what
25 -- you listen and then -- and then you interpret after a

1 period of time. It seems what you're saying right now
2 is such and such. You've convinced you're going to have
3 surgery or you're not so sure anymore.

4 **Q How old were the people?**

5 A The key thing in therapy is that you follow
6 the patient and that we have guidelines and I've done
7 that in my work. Yeah.

8 **Q How old were the three to four patients at**
9 **Buckhorn that you were discussing?**

10 A 15 maybe.

11 **Q All of them are 15?**

12 A I don't know. Maybe one 14; maybe one 16.

13 **Q What about the one you're currently treating?**

14 A She is now 17. She's just stopped wearing a
15 binder and is no longer talking about it. I actually
16 haven't asked her about it for a month or two but...

17 **Q So she -- has she at some point identified as**
18 **being transgender?**

19 A She thought she was. I would say yes, but --
20 but then it became not so sure.

21 **Q Do you discuss this patient with Dr. Brady?**

22 A No.

23 **Q Have you ever?**

24 A No.

25 **Q Have you discussed this patient with anyone at**

1 **the Bingham Clinic?**

2 A I don't think so. I see her family. I see
3 her sister as well for various problems so it's a family
4 kind of case but...

5 **Q So you treat her whole family?**

6 A Yes.

7 **Q Why haven't you discussed this transgender**
8 **person who at some point identifies transgender with Dr.**
9 **Brady?**

10 A Because I don't have to. She's not authorized
11 to do this. And the case is actually going very very
12 well. And I'm not sure Dr. Brady could handle this. She
13 doesn't have enough experience.

14 **Q What do you mean, "Dr. Brady's not authorized**
15 **for this?"**

16 A Well, she's been with us a year-and-a-half,
17 maybe a little longer. I could have discussed it with
18 her, but I didn't think that she would have anything to
19 offer that would help me.

20 **Q Where do you work with the whole family? What**
21 **physical location?**

22 A It would be the Bingham Clinic.

23 **Q How many times have you seen that patient and**
24 **their family?**

25 A Oh, my goodness. Almost three years. Maybe

1 three-and-a-half years now.

2 **Q Did you -- do you discuss any of your patients**
3 **at Buckhorn with any of the other people in your**
4 **department? Or is it just all by you?**

5 A Mostly by me. If I have a question, I might.
6 Again, you realize, I practice psychiatry for 42 years
7 and I'm the boss of the clinic and, you know, there's a
8 certain, why would I do that. But from time to time,
9 they're interesting questions. I'm an academic. I
10 enjoy discussing it with physicians when there's time.

11 **Q Wait. You have the clinical -- what did you**
12 **call it? Like the meeting where you discuss your case**
13 **you're working on.**

14 A Clinic case conference. Yeah. Yeah. So you
15 ever discuss your cases that you're working on?

16 A Yeah. Several times I've done that.

17 **Q Have you ever discussed --**

18 A I actually brought it up with Dr. Brady that
19 we should discuss some of her cases, but she declined.

20 **Q Have you ever reviewed any of Dr. Brady's**
21 **cases with her?**

22 A I did when I visited the clinic with her two
23 months ago. We discussed those cases at length. But it
24 was not the spirit of academic inquiry that I wanted in
25 the division. It was clear that we weren't going to be

1 able to get anywhere, because my reviews that frankly,
2 she didn't like.

3 **Q Reviews about transgender patients?**

4 A Yeah. I mean, one -- the one girl I saw was
5 getting treated with hormones after she had seen the
6 case twice. I didn't feel that people understood well
7 enough at all what was going on. But you get the drift.
8 I mean, it's not easy to have a conversation with that
9 kind of situation.

10 **Q Okay. Other than discussing those two cases**
11 **when you went to the gender clinic on that one occasion,**
12 **have you reviewed any other cases with Dr. Brady that**
13 **involved transgender patients?**

14 A She's not presented any to us or conferences
15 or brought it to our attention. I've encouraged her to
16 do that. So I think the simple answer would say no.

17 **Q Have you reviewed any other person in your**
18 **department, have you reviewed any of their -- sorry, let**
19 **me start over. Other than Dr. Brady, is there anyone**
20 **else in your department that treats transgender youth,**
21 **that you review their treatment with?**

22 A I don't review their treatment. No. I trust
23 their treatment and what they're doing.

24 **Q Do you trust Dr. Brady's ability to treat**
25 **transgender patients?**

1 A Dr. Brady has solid clinical skills. And I
2 think she provides good care to them. My concern is
3 that revision is unifocal and she's so passionate about
4 her provision of care to them, that she doesn't see the
5 bigger picture.

6 Q What do you mean?

7 A Well, I think she would find it difficult to
8 look at a case and see that the patient may not be
9 transgender.

10 Q Have you ever asked her in working with any of
11 her patients, the patient has decided they didn't want
12 further medical treatment?

13 A She's told me she's had some. And what's
14 happening is that with the tsunami that I mentioned, the
15 growing number of these kids, many of whom are not going
16 to be transgender, that her task is to design help
17 others, help clinicians sort out which ones are real and
18 which ones are not real because it's going to get more
19 and more difficult to do that.

20 Q So you would agree that she doesn't rush to
21 affirm someone's --

22 A She did in that one case, I believe. But I
23 don't know her practice. I have no idea.

24 Q Let me just finish my question, okay? So your
25 opinion is that she rushed to affirm one of the patients

1 **when you went to the gender clinic with her?**

2 A Yes.

3 **Q Which patient?**

4 MR. KOSTELNIK: I'm going to object. If
5 there's a name, it's going to be HIPAA protected.

6 A Yeah. I hope to remember. 16-year-old girl,
7 15-year-old girl.

8 **Q Why do you say, "She rushed to affirm"?**

9 A It was a complicated case. She had a severe
10 anxiety disorder. As best I could determine, again, I
11 wasn't asking questions but trying to piece it together.
12 This was on the second visit. And when I left the room
13 a nurse came in with a needle.

14 **Q Did you review that person's medical records,
15 that patient?**

16 A No. No. I didn't.

17 **Q Did you ask Dr. Brady for the full background
18 of that patient's medical history?**

19 A To the extent that we had time, we looked at a
20 good bit of it. But, I'm sure there were parts I didn't
21 know.

22 **Q Did you tell Dr. Brady you disagreed?**

23 A That I disagreed with?

24 **Q It sounds like the patient was being --**

25 A No. We didn't get into that. No.

1 Q Did you tell her you had any concerns the way
2 she was treating the patient?

3 A I did not say that in which subsequent events
4 which would have unraveled very quickly. There's really
5 no basis for further conversation with her. I wish
6 there were, but there's not.

7 Q Is this the individual you're referring to
8 when you spoke at The Heritage Foundation panel, when
9 you talked about --

10 A No.

11 Q -- one of your colleagues?

12 A No.

13 Q So do you trust Dr. Brady's judgment?

14 A Oh, I think her judgment is sound in other
15 clinical matters. I just think she -- and she's not
16 alone in this, has some blinders with respect to this
17 patient population.

18 Q Do you have an understanding that she
19 following WPATH's guidelines?

20 A I understand that. Yeah.

21 Q And she follows the Endocrine Society's
22 Guidelines, along with Dr. Kingery, the endocrinologist?

23 A Yes.

24 Q And she's a member of WPATH, right, Dr. Brady?

25 A I think she might be. I'm not sure.

1 **Q Do you have any concerns about her ability to**
2 **leave the gender clinic?**

3 A It's -- it's all we got. And that's who is
4 leading gender clinics in this country right now. People
5 who have a very focused view on things.

6 **Q And you follow WPATH and endocrine society**
7 **guidelines, right?**

8 MR. KOSTELNIK: Form.

9 A I'm assuming they do.

10 **Q How many transgender patients would you**
11 **estimate that Dr. Brady has treated since she's been at**
12 **that gender clinic at UofL?**

13 A That's a good question. I believe she has
14 just been with us two years now. And she didn't start
15 doing that right away. Probably maybe a year ago. So
16 she's there maybe three weeks out of four. Sees two
17 patients per visit. Maybe three. So that's what, maybe
18 40 patients, 50.

19 **Q You think she's treated more transgender youth**
20 **than you have?**

21 A She might have seen more. The challenge right
22 now for Dr. Brady is, she's forced to do a lot of brief
23 evals. And then when she's going to see the patient
24 next, it may be a month from then because she just
25 doesn't have any time. Probably what will happen with

1 her career, she'll stop doing oncology and do
2 transgender full time in my sense, but -- but she just
3 has trouble seeing all the patients that are cropping up
4 everywhere.

5 **Q And Dr. Kingery, Suzanne Kingery, the**
6 **pediatric endocrinologist who works in the gender**
7 **clinic, do you have any reason to question her ability**
8 **to do her job at the gender clinic?**

9 A No.

10 **Q You would agree she's competent and**
11 **knowledgeable?**

12 A I mean, I really have no basis to -- to say
13 that, but I have no basis to not say it. I just don't
14 know her.

15 **Q Did you happen to interact with Dr. Kingery**
16 **when you went to the gender clinic on the --**

17 A I said, "Hello." And I don't know whether Dr.
18 Brady had -- had made her aware that I was coming. So I
19 saw her sitting at the desk there and said, "Hello," and
20 that was it.

21 **Q As CEO of Bingham Clinic, do you have job**
22 **duties that are administrative in nature?**

23 A Yes.

24 **Q Okay. And do you also teach at the**
25 **university?**

1 A Yes.

2 Q Okay. And then you treat patients, correct?

3 A Yes.

4 Q Okay. Can you breakdown in terms of
5 percentage of your time that's devoted to
6 administrative, teaching, or interacting with patients?
7 Or any other job duties you might have.

8 A Sure. Yeah. My situation is complex, but not
9 unlike other academics. And it really involves four. So
10 the administrative part that would be roughly 40
11 percent, maybe 50. It needs -- it means administering
12 the activities, which is recruitment, retention,
13 evaluation of faculty, meeting budgets, meeting with
14 various departmental and medical school faculty staff as
15 it interacts with child psychiatry. We just recently
16 embarked on a plan to change some of the positions of
17 leadership so Dr. Peters is becoming director of
18 outpatient services. Dr. Stocker is becoming director
19 of community base services of Bingham -- Bingham
20 community services. Dr. Le is becoming training
21 director. Dr. Carr is becoming the social impatient
22 director. These are all kind of major shifts that I'm
23 overseeing trying to help them in their new -- their new
24 jobs. Now, one other thing about administration, we
25 have a very unique structure. And, in fact, in part, I

1 have two jobs. So the CEO of the Bingham Clinic -- I
2 realize I'm going on here, but whatever.

3 Q Well, yeah.

4 A Briefly.

5 Q Yeah.

6 A The CEO of the -- the Bingham Clinic is a
7 private non-profit clinic that has been in the community
8 over 100 years. It existed before the medical school
9 division. The medical school division, child psychiatry
10 appropriated that. And so I worked with a community
11 based board and all that stuff. But really quickly, so
12 then I teach medical students some lecturers, general
13 residents, our own child psychiatry residents and see
14 some patients as we've discussed. In terms of my
15 academic work, I write and public in areas primarily of
16 developmental psychopathology and family systems.

17 Q Okay. So what percentage of your time would
18 you say is devoted to teaching?

19 A Okay. So teaching would be maybe 20 percent.
20 I said what, 40 to 50 administration? And then patients
21 would be 30 and academic work, what is that?

22 Q About ten percent.

23 A Not much left. Maybe ten at most. Yeah. That
24 really --

25 Q Okay. What prompted the changes in the

1 **department of different leadership roles?**

2 A We've developed and grown. And when we
3 started, it was basically me and a couple of people. And
4 so I did many of the activities. We're now grown. These
5 people are mature in their careers. Some of them wanted
6 changes to do something new. And so it just seemed a
7 time to do this.

8 Q I'm changing gears here a little bit. So when
9 you submitted your expert reports in the North Carolina
10 and Illinois cases in 2016, you had -- you indicated on
11 those reports you had only treated 35 patients. Does
12 that sound accurate?

13 A Yeah. Back then. It's picked up its pace
14 considerably since then. Yeah. So I -- I guess. These
15 are all estimates again.

16 Q Okay.

17 A Over 30 year.

18 Q And I can show you your report, but...

19 A Yeah. I'm sure it's less. I didn't rule that
20 the number was 3 -- was it 35, you said?

21 Q Yeah. For the North Carolina one, August 11,
22 2016 it said there were "35 transgender patients" that
23 you treated.

24 A Okay.

25 Q Does that sound correct?

1 A Yeah. Yeah.

2 Q Okay.

3 A And then -- so it's about a year-and-a-half
4 ago and now it's increased to 60ish.

5 Q Okay. So it's nearly doubled in a
6 year-and-a-half?

7 A Yeah.

8 Q Okay.

9 A No. It's growing here. Yeah.

10 Q How did the number -- well, strike that. Did
11 you seek out transgender patients in your work?

12 A I didn't seek them out because I think two
13 things are happening. One, they're around more often.
14 They're there. And when I was asked to look at this and
15 some of the issues, I began to study, research, read,
16 consult, see more of them. And I then realized I was
17 learning much more and wanted to see more, so it was
18 kind of a natural transition.

19 Q Did you -- strike that. Were you recruited to
20 be an expert witness on issues relating to transgender
21 patients?

22 MR. KLOSTERNIK: Form.

23 A Recruited? People asked me. I mean, --

24 Q You know Dr. Ruse, correct?

25 A Yes. He's published.

1 Q Yeah. And you met him -- did you meet him at
2 a conference put together by Alliance Defending Freedom?

3 A I met him, first of all, because we were both
4 joint experts in the North Carolina case. So I kind of
5 met him through his writing. And I'm trying to think
6 the very first time I met him in person.

7 Q Did you ever attend a conference put on by the
8 Alliance for Defending Freedom?

9 A When would that have been?

10 Q Well, Dr. Ruse testified that he met you. Let
11 me find -- okay. Testified that he met you at a
12 conference put together by Alliance Defending Freedom.
13 Does that sound correct to you?

14 A Yeah. There would be two conferences. And
15 he's probably referring to the first one which occurred
16 in February of -- was that this year? Yeah. A lot has
17 happened. February of this year I met him. Yeah.

18 Q Okay. Had anyone at Alliance Defending
19 Freedom or any other entity approached you about being
20 an expert witness with regard to transgender patients?

21 A That's where it happened. Yeah. I had some
22 brief preliminary contact with them. Informally talked
23 with them around -- actually, it was some school kind of
24 issues in California. One thing led to another in part
25 stimulated by me saying, "I would like to meet you folks

1 just rather than have phone calls." And I was going
2 through Atlanta to a meeting. Had a cup of coffee with
3 a couple of their people in Atlanta. That was when the
4 North Carolina case was just breaking so I got a call
5 the next week. "Could you help us?" I said, "What are
6 the issues?" And I thought I might be able to help
7 them. And that was the first time I worked with
8 Alliance Defending Freedom. They then backed out of
9 that case and someone else took over and, of course,
10 then the case stopped.

11 **Q Do you remember who contacted you at Alliance**
12 **Defending Freedom about being an expert witness?**

13 MR. KOSTELNIK: Form.

14 A The first one was probably three years ago.
15 His name was Jeremy Tedesco .

16 **Q Have you showed any drafts of any of your**
17 **expert reports to Alliance Defending Freedom?**

18 A Well, when they were involved with the case,
19 obviously. Like, --

20 **Q Which --**

21 A -- working on. Yeah.

22 **Q Okay. Working on your case. And they -- did**
23 **they retain you as an expert witness in that case?**

24 A Yes.

25 **Q Okay.**

1 A And then it quickly went to another legal
2 firm. I didn't work then for Alliance for Defending
3 Freedom, but that brief work seemed productive enough to
4 them that they called me about another case. I think
5 that became the Illinois case. And then I did two
6 others with them.

7 **Q What were the others you've done with them?**

8 A Well, I think all the reports you mentioned
9 were Alliance Defending Freedom. Illinois, Ohio,
10 Pennsylvania.

11 **Q Did you show your -- any of your drafts of**
12 **your rebuttal report in this case to anyone at Alliance**
13 **Defending Freedom?**

14 A No.

15 MR. KOSTELNIK: Natalie?

16 MS. NARDECCHIA: Yes.

17 MR. KOSTELNIK: Can you give the court
18 reporter?

19 MS. NARDECCHIA: Yeah. Let's go off.

20 VIDEOGRAPHER: The time is 3:15 and we are off
21 the record.

22 (OFF THE RECORD)

23 VIDEOGRAPHER: It is 3:25 and we are back on
24 the record.

25 BY MS. NARDECCHIA:

1 Q Have you discussed your opinions that you're
2 offering in this case with anyone, other than
3 defendant's counsel?

4 A No.

5 Q So you haven't talked to Alliance Defending
6 Freedom of your opinions in this case?

7 A No.

8 Q I also noticed in the Boyertown report that
9 you submitted on July 7, 2017, you wrote that you had
10 treated 50 patients; does that sound accurate?

11 A I guess.

12 Q It was --

13 A These were all predicated with, approximately
14 -- I don't keep a record of everyone I see numerically.
15 So, yeah, it's creeping up. It's more than 35. I said
16 50, and I guess I now say 60.

17 Q Okay. So between July of this year and
18 October 2nd of this year, you saw ten more transgender
19 patients?

20 A Yeah.

21 Q Yes. Where did you see them?

22 A Well, these would have been probably two in
23 the outpatient, two upstairs inpatient, and four at
24 Buckhorn.

25 Q And these are all new patients?

1 A The -- yeah. I mean, there might have been --
2 when I gave the report in July and then one again in
3 October, there might have been one Buckhorn girl that
4 was a carryover, you know, that was there in July. But
5 otherwise, they would be new patients. Yes.

6 **Q And you understand that it's important to be**
7 **accurate in explaining your qualifications in an expert**
8 **report, correct?**

9 A Yes.

10 **Q Okay. So when you said you'd treated,**
11 **evaluated, or consulted with 60 transgender patients,**
12 **had you gone through to count how many transgender**
13 **patients --**

14 A No. I'm pretty sure I said approximately.

15 **Q Uh-huh. So you --**

16 A And this was a guess in a 35-year career,
17 right? So about this, but I realize it's important to
18 be accurate. Correct.

19 **Q But I was just asking: Did you go through and**
20 **count, based on records you had kept?**

21 A No. That's why I used the word
22 "approximately".

23 **Q Other than the Heritage Foundation panel, have**
24 **you ever given any other public presentations about**
25 **gender dysphoria or gender discordance?**

1 A I don't think so. No.

2 Q Just going back for a second. Do you have --
3 sorry. Let me start over. Are there records that you
4 have or have access to that would allow you to count the
5 number of transgender patients that you have treated or
6 evaluated or consulted with?

7 A No.

8 Q So it's just all based on your best estimate?

9 A Right.

10 Q There's no records of the treatment for any of
11 those 60 transgender patients?

12 A Well, there are records, but, again, we're
13 talking about probably 41 years since I began my
14 training in Minnesota.

15 Q Right. But you've -- I'm sorry. You've seen
16 --

17 A So the better records in the last -- the
18 closer you get to today, I could tell you the names of
19 the people. I'm not going to, but right -- that I'm
20 seeing right now. And it's probably, I guess, six or
21 seven. I don't know. No, I don't go every single one.
22 I could find the number of patients I've seen.

23 Q Are you required to maintain medical records
24 for specific periods of time?

25 A Medical records are always kept.

1 **Q Have you ever taught a class addressing gender**
2 **dysphoria or anything related to gender identity?**

3 A Apart from these case conferences and cases
4 when were discussed, and sitting in on Dr. Brady's
5 seminar, one with Dr. Peters, who also teaches at inner
6 clinic.

7 **Q So you said you sat in on one of Dr. --**

8 A Yeah. But I didn't teach --

9 **Q Sorry. Let me ask my question. You said you**
10 **sat in on one of Dr. Brady's seminars?**

11 A Yes.

12 **Q Which seminar?**

13 A She does an introductory hour lecture for the
14 psychology interns, and I believe the psychiatry
15 residents take part in that, and this year it was on
16 October 13th, and I sat in on it, 1:00 p.m. One hour.

17 **Q October 13th? Is that the --**

18 A But I don't -- I'm not identified as the
19 primary teacher.

20 **Q Is she identi -- is Dr. Brady identified as a**
21 **primary teacher?**

22 A Yes.

23 **Q Have you seen her curriculum or teaching about**
24 **gender dysphoria?**

25 A I've seen her slides of -- and some of her

1 outlines, but not the curriculum per se. In fact, I
2 don't think she -- I don't know where that's at. Again,
3 I've asked her to flush all that out for our clinic.

4 **Q So you didn't have to review her curriculum**
5 **that she's using for her seminar?**

6 A No. That would probably be Dr. Carter, the
7 disciplinary issues that psychologists look over,
8 psychologists. And I'm a psychiatrist.

9 **Q Why did you sit in on her seminar?**

10 A I like to know more about what she was doing,
11 and that's -- it may have even been the same day I went
12 to the clinic with her. I did so with her permission,
13 and so that's why I did that. I've done that with other
14 faculty, your junior faculty, just beginning faculty,
15 which Dr. Brady is, to try to get a sense of how they
16 teach, what their strength and weaknesses are, to try to
17 help them, so forth. In this case it was, obviously,
18 this area that was of interest to me, too.

19 **Q Would you agree with me that, generally,**
20 **people who are transgender face discrimination in the**
21 **world?**

22 A Yes.

23 **Q In what ways?**

24 A Well, I think there are differences, starting
25 physically or usually fairly obvious and people have

1 trouble with any kind of difference, let alone people
2 who look a little different. But you're tapping into
3 the roots of prejudice and stigma, and I'm not sure I
4 can give answers to that. But it's unfortunate, but
5 many of them do face those kinds of experiences.

6 **Q In your opinion, if someone is facing stigma**
7 **and discrimination for being a minority, can that be**
8 **harmful to them, their mental health?**

9 MR. KOSTELNIK: Form.

10 A Yes.

11 **Q Can you give examples of how that can be**
12 **harmful to their mental health?**

13 A Well, you would feel alone, feel not
14 supported. I think you could handle that fairly
15 directly if you had a group support from others and were
16 firm in your position. A lot of these individuals, as I
17 mentioned, are fluid or unsure, and they go back and
18 forth. And that's not a good combination to be alone
19 and to be unsure of yourself.

20 **Q Do you agree with me that -- I believe you**
21 **testified to this earlier; the transgender youth do face**
22 **discrimination, and harassment at school?**

23 MR. KOSTELNIK: Form.

24 A Yes.

25 **Q Would you agree with me that it could be**

1 harmful for a school to disclose a student's transgender
2 status?

3 A Yeah. I mean, if it hadn't been known by
4 anyone before, and usually, the students themselves pick
5 up on this before any administration would. But -- so
6 it's not quite confidential. But certainly it could be
7 harmful if it was just announced, and people -- they
8 knew something that they hadn't previously.

9 Q Would you agree it could be harmful because it
10 could expose that student to harassment or
11 discrimination or bullying at school?

12 A Yes.

13 Q Would you agree, on a broad level, that there
14 are some people that for whom their gender identity
15 differs from their sex? I know you don't use the word
16 "assigned", but the sex that they're determined at
17 birth?

18 MR. KOSTELNIK: Form.

19 A Yeah. Like identified or -- but so your
20 question, again, is?

21 Q Okay. So yeah. So I'm just not using the
22 word "assigned", even though that's what I -- because
23 I'm trying to use the words you use.

24 A Well, that's fine. No. That's fine.

25 Q Okay. So would you agree that there are some

1 people whose gender identity differs from the sex they
2 were identified as at birth?

3 A Yes. Clearly. That's been known for many
4 years.

5 Q Can that include children?

6 A Yes. And that's been known for years, too.

7 Q Can that include adolescents?

8 A Yes.

9 Q And adults?

10 A Yes.

11 Q And there's not consensus currently among the
12 scientific community about what causes someone to have a
13 gender identity that's different than their birth that's
14 designated -- I'm sorry, their sex that's designated at
15 their birth, correct?

16 A Yes.

17 Q Do you assume that people who are transgender
18 choose their gender identity, but cisgender people do
19 not?

20 MR. KOSTELNIK: Form.

21 A I think there's probably more of an element of
22 choosing for the transgender. The cisgender person, for
23 the most part, it just happens. You don't even think
24 about gender, per se.

25 Q But don't you think there are some people who

1 are transgender that they don't think about it. It's
2 just when they're -- even when they're very small, it's
3 who they are? Don't you think there are people --

4 A There will probably be people like that. Sure.

5 MR. KOSTELNIK: Form.

6 A And they're -- they may be growing, as I
7 mentioned. I think they are growing in number.

8 Q Is there anything wrong with following WPATH
9 guidance that says if a child expresses or question
10 their identity, to let them explore that, and not
11 prevent them from living in that way? In other words,
12 to let them be who they are, who they're saying they
13 are; is there any harm in that?

14 MR. KOSTELNIK: Form.

15 A Yes.

16 Q What's the harm?

17 A Because children don't know who they are about
18 lots of things. And it's the parents' role, job to
19 guide them, to instruct them, to show them, and you can
20 respect the individuality of a child very easily. But
21 also give them the facts about the world.

22 Q But what's the harm to the child if they -- if
23 their parents allows them to do that?

24 A Well, they feel less sure of who they are, and
25 their identity. The biology is there for a reason, and

1 the fact that they may not align with that, that
2 potential will confuse them. Harm is an interesting
3 word, as we discussed earlier today. Children need to
4 be given guidance about the world structure, let the
5 world know that there's someone there to explain the
6 world to them, and hopefully, have those who are
7 explaining the world to them, their parents giving them
8 the right answers. And if they're not the right
9 answers, it potentially can be a confusing early
10 experience in life.

11 **Q Well, part of what's real in our reality is**
12 **that there are transgender people, right? So --**

13 **A Correct.**

14 **Q -- that's part of what a child's reality**
15 **nowadays can include, right?**

16 **A It's increasingly including that. Yeah.**

17 **Q So telling a child that there are people who**
18 **are transgender, and that's okay if that's who you are.**
19 **That's part of their reality around them, as well,**
20 **right?**

21 **MR. KOSTELNIK: Form.**

22 **A There are more of them. I think, again, they**
23 **need to be taught and educated about that, but this**
24 **phrase about who they are, that's very tricky because**
25 **children don't know that without guidance and**

1 instruction. It gets modified later on, but who they
2 are is directly related to the input and structure that
3 parents give them.

4 **Q It has nothing to do with who they inherently,**
5 **just their identity?**

6 A No. Who you are is shaped by your biology to
7 some extent, but it's not all determinate. What you
8 experience in life comes from family, parents who are
9 the first teachers, and this is the way the world works.
10 In fact, that's a fundamental part of an effective
11 parent.

12 **Q Are you aware of a 2015 study by Dr. Olson,**
13 **who we've talked about? It's entitled, "Gender**
14 **Cognition in Transgender Children", which shows that**
15 **transgender pre-progressing children identify as**
16 **consistently, and innately with their gender identity of**
17 **their cisgender peers.**

18 MR. KOSTELNIK: Form.

19 A I saw that study in the past. I might look it
20 up again, but I can't comment on it. When was that
21 published?

22 **Q 2015.**

23 A Again, a lot of these recent studies -- we
24 just need to look at follow-up, and do the findings
25 hold, and was the methodology sound? But

1 MS. NARDECCHIA: I need to mark this as Exhibit

2 1. Yeah. Thank you.

3 (EXHIBIT 1 MARKED FOR IDENTIFICATION)

4 **Q Take a minute. Let me know when you're ready.**

5 A Right.

6 **Q All right.**

7 A I've asked for this several times. I hadn't
8 received it, but now I see it. Okay.

9 **Q Do you know what this is?**

10 A Well, it's a lecture outline from Dr. Kingery,
11 it looks like.

12 **Q And Dr. Kingery is a -- it looks like it's a**
13 **PowerPoint presentation.**

14 A Right. And it looks like she is preparing
15 this for -- it's not sure whether it's adolescents or --
16 is this for me?

17 **Q This is the exhibit that will stay with the**
18 **deposition.**

19 A Oh, it's an exhibit. Yeah. Because I have
20 asked for this. It's not been sent to me. Okay.

21 **Q This was produced by University of Louisville.**

22 A Right. They're sending me all that other
23 stuff, too, which I apologize didn't get to me before
24 this, but go ahead.

25 **Q So if you could turn to page 18 of this**

1 document. Do you see the top slide that's entitled,
2 "Awareness of Gender Identity"?

3 A Yep.

4 Q Okay. Do you agree with the content of that
5 slide?

6 A For the most part, yeah.

7 Q Anything you disagree with?

8 A I wouldn't disagree with anything except it's
9 a spectrum. It's a fluid spectrum of concepts. But the
10 way we teach, often, is the way she does it here. Age
11 one, two, three, four.

12 Q Okay. Put that one aside. Is it your opinion
13 -- I'm sorry. Yeah. I don't have any more questions
14 about that one.

15 A Okay.

16 Q I know you want to look at it.

17 MR. KOSTELNIK: Here. I'll take it from him.

18 Q Your attorney --

19 A That's fine. I'll be getting it tomorrow. So
20 that's okay.

21 Q Okay.

22 MR. KOSTELNIK: I can get it to you.

23 A But I'm an academic. I want to discuss it for
24 15 minutes, but we're not going to. Go ahead.

25 Q Is it your opinion being transgender means

1 that you are unhealthy?

2 A I wouldn't say that. No.

3 Q Do you agree with Endocrine Society guidelines
4 that transgender patients who undergo transition related
5 care have the same risk factors for their long-term
6 health as cisgender peers who have similar hormone
7 profiles?

8 MR. KOSTELNIK: Form.

9 A You know, there's just different research of
10 long-term outcomes. But to say -- to equate them with
11 cisgender is real tricky. Okay.

12 Q So you -- do you agree or...?

13 A Well, all I'm saying is we don't know, and the
14 science is unsettled. But to take a position where you
15 reject your biology, go through dis-forming surgeries,
16 alter your chemical milieu, and say outcomes are going
17 to be the same of someone who does not do those things,
18 we don't know that yet.

19 Q So you don't -- you're -- sounds like you're
20 not in agreement with that statement.

21 A I would -- as a scientist, I would like to see
22 -- yeah. See that followed up five or ten years. The
23 thrust of all this, of course, is this is totally normal
24 behavior, and I have questions about that. We need to
25 study it further.

1 Q What is totally normal to you?

2 A The trans -- you just said it, transgender is
3 no different than cisgender in terms of developmental
4 trajectories.

5 Q Well, this was saying in terms of health
6 risks.

7 A Well, I mean, if the data are there, the
8 health risks, you know, the widely quoted study from
9 Sweden several years ago, says directly the opposite.
10 And that followed individuals for 30 years, so

11 Q You're -- are you referring to the Swedish
12 study by -- the person's last name is D-H-E-J --

13 A Yes. Yes. Correct.

14 Q -- N-E? Okay. Yeah. That study -- isn't it
15 true that that wasn't a controlled study; that the
16 control group was the background population?

17 A Well, they matched the population, patient
18 population, with other individuals. I'm not -- I can't
19 remember what the match was, but

20 Q And didn't that study explicitly say that
21 medical transition is supported by other research,
22 including the 2009 Swedish study?

23 A I think they said that, but they also had
24 other striking findings about mental health outcome, and
25 hospitalizations, and mortality, and physical health. So

1 my point is, when these things come out now, and I don't
2 know if it's productive for us to argue about studies.
3 But the length of time is very important. This, again,
4 didn't start in North America. It's less than ten years
5 ago, and in Louisville, less than three years ago. And
6 we just don't know a lot yet.

7 Q Well, I want to ask you about the study
8 because it appears, to me, and, in fact, let me strike.
9 Just ask my question. Are you aware that the author
10 says her work has been misrepresented, and that gender
11 confirming interventions reduce gender dysphoria?

12 A And this is which person?

13 Q Last name D-H-E-J-N-E.

14 A Okay. So she has made that statement.

15 Q Are you aware of it? I mean, yes, I read --

16 A I was aware of that statement.

17 Q Okay. I've read an article that says that,
18 but --

19 MR. KOSTELNIK: Form.

20 Q -- have you --

21 A That says what?

22 Q What I just read.

23 A What you -- yeah. So then she probably said
24 it.

25 Q Okay. Do you believe, as a psychiatrist, that

1 all effort should be made to increase transgender
2 individual's opportunities for well-being in society?

3 A Yes.

4 Q And you agree, don't you, that gender
5 deferring treatment reduces gender dysphoria that
6 adolescents face?

7 MR. KOSTELNIK: Form.

8 A As mentioned earlier, I think it does in the
9 short run. Yeah.

10 Q Okay. I want to ask you about some specific
11 statements that you made in your report. You wrote that
12 a "transgender identity" is inherently pathological, and
13 indicative of mental illness. Is that your opinion
14 you're offering?

15 A When did I write that? I tend not to like the
16 term mental illness, but

17 Q Do you want me to read the sentence I was
18 referring to?

19 A In which report was that?

20 Q This is your expert report.

21 A For this case?

22 Q For this case.

23 A And what was the number there?

24 A Paragraph 20. Do you want me to put your --
25 here. Let me just put my -- your report as an exhibit.

1 A That's all right. I've probably got it over
2 here. Okay.

3 MR. KOSTELNIK: Let her enter it as an exhibit,
4 and then you can review it while she's asking you
5 questions.

6 THE WITNESS: Okay.

7 MS. NARDECCHIA: This will be Exhibit 2. Thank
8 you.

9 MR. KOSTELNIK: Thank you.

10 (EXHIBIT 2 MARKED FOR IDENTIFICATION)

11 A You said number 20?

12 BY MS. NARDECCHIA:

13 Q Yeah. Paragraph 20. See this -- it's the
14 second sentence.

15 A Yeah.

16 Q So my question is: Are you offering an
17 opinion that the "transgender identity" -- well, not end
18 quote, is inherently -- sorry. I'm preparing this. Let
19 me just start over. Are you offering an opinion that
20 the transgender identity is inherently pathological or
21 indicative of mental illness?

22 A The -- I'm not stating it. I'm referring to
23 the criterion of mental disorder in the DSM5. And that
24 I didn't make this statement, but others do. That it's
25 not pathological or not indicative of mental illness.

1 What I'm trying to say there is that this interferes
2 with an individual's life function in society as we know
3 it, and interferes with relationships, and with Drew's
4 ability to go to the bathroom, that kind of stuff. To
5 have this, we have long held in the DSM system that you
6 either have signs or symptoms or pain or distress or
7 impairment in an important area of life function. And
8 an important area of life function would be to have a
9 stable identity that's consistent with the continuation
10 of the human race, and continuation with pro-creation,
11 and so forth.

12 **Q All right. So --**

13 A So if you deviate from that, it may meet a
14 criterion of the DSM. It's an important area of life
15 function that's missing.

16 **Q Okay. Do -- is it your opinion that being**
17 **transgender means that you have mental illness?**

18 A Right now with our current diagnostic
19 nomenclature, with gender dysphoria, yes, it does. As
20 we discussed earlier, some people do not have symptoms
21 and then it's debatable. They would not meet the
22 criterion of having a symptom for mental disorder, but
23 then it's debatable. Is this a deviation from an
24 important of life function from identifying as a new
25 gender, does that meet that criteria.

1 Q Do you believe that someone who's transgender
2 who's not suffering from gender dysphoria is mentally
3 ill because they're transgender?

4 A They may very well not be mentally ill. No.
5 But you'd have to look at what other areas of life
6 function that are affected by their choice to change
7 their gender. And there might be. But it's not kind of
8 automatic. If something -- if somebody's dysphoric,
9 depressed or anxious by definition, they have a mental
10 disorder.

11 Q Are you aware of the American Psychological
12 Association guidance that says, "Making the assumption
13 that psychopathology exists given a specific gender
14 identity or gender expression is a form of
15 discrimination"?

16 A Where does that come from? I'm not surprised
17 that it's there, but

18 Q That's in the American Psychological
19 Association guideline.

20 A Can you give me a page there or something?

21 Q No. I don't have that in front of me, but are
22 you --

23 A That's fine.

24 Q -- aware of that?

25 A I wanted to look at that, and study that.

1 That's an unfortunate confluence, conflation of a civil
2 rights term in medicine. There's no question that
3 people are discriminated against as we've discussed, and
4 so forth. But to say making a diagnosis is an
5 infringement of -- what was the phrase, civil rights; is
6 that what you said?

7 Q No. It said "Making the assumption that
8 psychopathology exists given a specific gender identity
9 or gender expression is a form of discrimination." You
10 don't agree. I'm taking with the --

11 A Well, I don't -- to diagnose is never a form
12 of discrimination. Now, the challenges in the real
13 world, as I've said, the vast majority of these kids
14 have lots of adolescents sometimes, but symptoms to be
15 diagnosable. But if, as in the Dhejne study, if people
16 come through clean, they have an adjustment; we could
17 not say they have a mental disorder. No.

18 Q But this is not talking about diagnosis. I'm
19 just asking you: Do you -- well, strike that. Do you
20 acknowledge that labeling all transgender people as
21 mentally ill is a form of discrimination?

22 MR. KOSTELNIK: Form.

23 A Well, first of all, I wouldn't label them all
24 mentally ill. But if they meet criteria, it's not a
25 form of discrimination. It's a diagnosis.

1 Q You mean if they have gender dysphoria, you
2 would say that they're mentally ill?

3 A Right. If they have symptoms, and then this
4 debatable what important area of life function would
5 they have that is a problem for them. So they could
6 very well meet -- but not automatically. There could be
7 those transgender who are fine, and would not meet a
8 mental disorder diagnosis.

9 Q Okay. So --

10 A Yeah. They're out there.

11 Q -- you agree, being transgender does not mean
12 you're -- you have a mental illness?

13 A Agree.

14 Q Okay. So you also indicate in paragraph 20
15 that "Transitioning could have long term psychosocial
16 morbidity." Is that your opinion?

17 A Right. So I'm making a prediction, but say we
18 don't know. And that's why the Swedish study, the study
19 that you mentioned, needs to be followed out. My
20 position would be if you're making these dramatic
21 changes in the given biological condition, the nature of
22 the human, like this, we don't know where it's headed.

23 Q So, in other words, there is no evidence that
24 people who transition are going to have long-term
25 psychosocial morbidity, correct?

1 A Well, depends on whether you like the Swedish
2 study. I mean, I'm --

3 Q So that's -- other than that Swedish study.

4 A And there may be others, but I'm not
5 predicting it. It is possible that they will remain
6 without symptoms.

7 Q What is the basis, scientific basis, for your
8 prediction on that; that people who transition won't
9 experience long-term psychosocial morbidity?

10 A Well, if you notice, I qualified that. So we
11 don't know. It's likely my hypothesis, and my basis
12 would be

13 Q It's your untested hypothesis, in other words?

14 A I suppose you could say that, although there
15 are lots of things that are untested here. And many of
16 the studies that you refer to are just too early for us
17 to know.

18 Q So you put in your expert report pure
19 speculation that transgender people may become mentally
20 diseased if they transition?

21 A What number is that?

22 Q That's at paragraph 20.

23 A I did not use the term mental disease, and
24 would not support that term. Long-term psychosocial
25 morbidity means problems.

1 **Q But it doesn't -- doesn't it mean mental**
2 **illness?**

3 A No.

4 **Q Mentally diseased.**

5 A No. It means that sadness, dysphoria, fitting
6 in with society, long-term relationship difficulties,
7 the kind of psychosocial issues. Although, this is not
8 known at the present time.

9 **Q Do you think it's helpful for the court to**
10 **include pure speculation about what may happen to**
11 **transgender people if they transition?**

12 MR. KOSTELNIK: Form.

13 A When it's qualified. I can't speak for what
14 the court takes as evidence or not, but I've made an
15 effort to qualify. Although, this is not known at this
16 time. I think that indicates a fair degree of academic
17 humility.

18 **Q Is it your opinion that being transgender**
19 **equates to maintaining a delusion about reality?**

20 A The definition of delusion, of course, is a
21 fixed false belief. Many people have an emotional
22 response to delusion, so it probably isn't a good term
23 in that sense. But, factually, you remain -- even for
24 Drew, he remains a female, although feels male. And on
25 the other hand, boys who transition remain boys, even

1 though they feel female. And to think otherwise is a
2 feeling. It's not a fact.

3 **Q So do you, then, take back your opinion that**
4 **you wrote in your expert report that a transgender**
5 **individual meets the technical psychiatric criterion for**
6 **maintaining a delusion?**

7 MR. KOSTELNIK: Form.

8 A I wouldn't take that back because it's
9 technically accurate. But it leads to a discussion that
10 many people find difficult.

11 **Q But you --**

12 A Because there's not an accusatory thing. It's
13 just that it's definitional fact. If you believe
14 something is not true, a psychiatrist says, that's a
15 delusion. Other people have used softer terms, like
16 false assumption, misguided assumption, and so forth.
17 But it's the same thing.

18 **Q The delusion you're referring to is that is**
19 **how that person identifies; is there a gender identity?**
20 **They have a delusion about their gender identity; is**
21 **that your opinion?**

22 MR. KOSTELNIK: Form.

23 A No. They're not delusional about their
24 general identity. Believe that they're a woman, but
25 physically they're a man. But they feel differently.

1 **Q And that's true for all transgender people; in**
2 **your opinion, that they have a delusion that they are**
3 **one sex, and they're really the other?**

4 **A Well, that would be true of all transgender**
5 **people. Yes.**

6 **Q No matter where they have gone in their**
7 **transition?**

8 **A The individual who goes through all those**
9 **transitions can function as a male, should be treated as**
10 **a male, like, for example; should be respected as a**
11 **male. Those things are fine, and life can go on. And**
12 **they can try to adapt in those situations, and many**
13 **people will, many people won't. But it's still a**
14 **feeling that you have in that it does not change your**
15 **basic nature.**

16 **Q Are you aware of WPATH's standards of care**
17 **that specifically reject the notion that having gender**
18 **dysphoria is a delusion, and state, "Inexperienced**
19 **clinicians may mistake indications of gender dysphoria**
20 **for delusions"?**

21 **A Well, it's hard to mistake that, I mean,**
22 **because it's a statement of fact. And I think what**
23 **they're responding to there is the emotions that are**
24 **engendered by the term delusion, which I will**
25 **acknowledge are significant. I think people have**

1 trouble seeing back that. So in the future, I'll
2 probably use fixed false assumption or something. And
3 it's not unlike -- as I'm sure you're aware, the other
4 comparison medicine, and there are others, of patients
5 who believe things are not true. And the classic
6 example is anorexia of ulcer patients who believe
7 they're fat. And it's not true.

8 **Q So you're going to, from here on out, stop**
9 **referring to transgender people as being delusional**
10 **because you think some people may not like that?**

11 MR. KOSTELNIK: Form.

12 A Well, I think if one thinks a lot about
13 communication, which I do, I'm going to give that some
14 thought because it creates the problems that we're just
15 having right now. People move beyond the cognition of
16 the statement, the fixed false belief.

17 **Q But it's not false. It's their gender**
18 **identity, right?**

19 A Well, it's no big deal.

20 **Q It's not false or true. It's their gender**
21 **identity, correct?**

22 MR. KOSTELNIK: Form.

23 A Yes. It is their gender identity. Right.
24 Yeah.

25 **Q Is it possible that you are an inexperienced**

1 **clinician in the area of gender dysphoria, and are**
2 **making the same mistake that WPATH warns -- cautions**
3 **against?**

4 MR. KOSTELNIK: Form.

5 A No.

6 **Q Your opinion on transgender people being**
7 **delusional is clearly out of step with WPATH, then,**
8 **correct, on this point?**

9 A It would be if that's what they were stating
10 in that particular issue. Yeah.

11 **Q Have you read the WPATH guidance?**

12 A Yes. I have. It's been a while since I
13 looked at their standard of care. I know they've
14 updated it, and, you know

15 **Q Does any medical professional group, that**
16 **you're aware of, agree with your opinion that**
17 **transgender people are delusional?**

18 A Any professional group?

19 **Q Yeah.**

20 A I'm not sure apart from WPATH professional
21 groups have made specific statements about that. But I
22 suspect they might have some trouble with it. Correct.

23 **Q Other professional groups may have trouble**
24 **with your statement that transgender people are**
25 **delusional, right?**

1 A Yeah.

2 Q Is there ever an instance in which you would
3 accept that a transgender person is not delusional?

4 MR. KOSTELNIK: Form.

5 A If you've changed your various aspects to your
6 appearance, but have not changed your genetic structure,
7 what you were born with, and now believe that you're
8 female, and live that way, you're still a male, even
9 though you feel that you're female. There's nothing
10 wrong with that. You can be successful with that. But
11 just wishing that you change the nature of reality is
12 not enough to change it.

13 Q Do you also believe that gay and lesbian
14 people are delusional?

15 A About what fact?

16 Q About their sexual orientation.

17 A No. No. That's how they feel. It's a
18 feeling.

19 Q It's their identity, right?

20 A It's their identity. Yeah.

21 Q And you don't think they're delusional about
22 their identity?

23 A It's a different situation. They're not
24 changing the nature of their biology or their sex, which
25 is recognized and identified at birth.

1 Q Is there any other subset of the population
2 that you believe is delusional about their identity,
3 other than transgender people?

4 A Well, I mentioned anorexia of ulcer
5 patients. Now that ceases with treatment, but they
6 often believe things that are not true. There is rare
7 syndromes like phantom limb syndromes. People think
8 they do or do not have a limb. And I think just
9 declaring something, feeling something is not enough to
10 make it true.

11 Q Okay. I want to just go back to paragraph 20
12 to ask you one more question of your report.

13 A Okay.

14 Q The part that talks about the potential long-
15 term psychosocial morbidity. How -- what methodology
16 did you use to come to that opinion that there may be
17 long-term psychosocial morbidity for transitioning?

18 A Well, it was not subjected to a measurable
19 study, but I would just say it's a massive experiment
20 that we're engaged in that increasingly people are
21 engaging in to eliminate your natal sex and to tinker
22 with biology like that may have consequences. But I
23 acknowledge that this is not known at this time.

24 Q DSM --

25 A Perhaps the statement likely is a little more

1 definitive, and that created a problem here for
2 understanding, but

3 Q DSM5, specifically, uses a phrase, "gender
4 dysphoria" instead of "gender identity disorder" --

5 A Right.

6 Q -- that was in DSM4, correct?

7 A Yes.

8 Q Yeah. But you still believe that gender
9 dysphoria is a mental disorder?

10 A Well, it's in the manual of mental disorders,
11 a specific criterion.

12 Q So "yes"?

13 A Yes. And there's vigorous moves to have it
14 removed, and it may very well happen.

15 Q Okay. If you -- you mentioned in your report,
16 at paragraph 33, if you want to look. You argued that
17 the transgender -- sorry, let me start over. "The
18 transgender position is often prompted by a variety of
19 issues." You see where you wrote that?

20 A Yep.

21 Q What is the transgender position?

22 A That a male would say he's female, and a
23 female says she's male.

24 Q Oh. So just someone identifying as being
25 transgender?

1 A Yeah.

2 Q Okay. What are all the variety of issues that
3 you believe can prompt someone to become transgender?

4 A Any of the issues that are overwhelm the
5 asexual societal expectations. So that, as I mentioned
6 earlier in my testimony, a young girl who perceives
7 certain things are required of her of a young woman
8 often relate in relationship to men, how she will
9 behave, is overwhelming to her. And she can't tolerate
10 the idea or think about the idea of being female.

11 Q Do you really believe that an adolescent girl
12 will decide she wants to just choose to be male because
13 being a girl is so hard; do you really believe that?

14 A Happens all the time.

15 Q With who?

16 A Patients I see, and treat.

17 Q Which patients?

18 A It's increasing, and I would refer you to the
19 Finland study, the Kaitola study, who essentially states
20 in layman's terms that we were blown away by the level
21 of pathology of these girls seeking sex assignment, and
22 re-assignment. And then I think it's an area of future
23 study. They don't do this consciously, but now this is
24 a different group of patients than the Dhejne study that
25 you quoted earlier, which is the tight, nice,

1 psychosocially strong group of people.

2 Q How many patients have you said, "I'm going to
3 not be a girl anymore because it's just too hard. I'm
4 going to be a boy"?

5 A How many patients have --

6 Q Have said that to you?

7 MR. KOSTELNIK: Form.

8 A In one way or another, a good number of the
9 Buckhorn girls say that. Of course, they're --

10 Q How many?

11 A Well, what did I say? I've seen 12 or 14 of
12 Buckhorn something. Three or four have said that.

13 Q Three to four out of 14 people?

14 A That doesn't mean the others haven't said
15 that, I mean, it's inferred. They are not happy with
16 their lives. These are unhappy kids. And this solution
17 is a solution that offers hope, and I understand that.

18 Q Any other issues that you believe can prompt
19 someone to be transgender?

20 A Well, you know, prompt is an interesting word.

21 Q Well, that's the word you used, right?

22 A Pre-dispose --

23 Q "The transgender position is often prompted by
24 a variety of issues."

25 MR. KOSTELNIK: Form.

1 Q That's your wording.

2 MR. KOSTELNIK: Form.

3 A I'm sorry. What number again, come back?

4 Q Paragraph 33.

5 A 33.

6 MR. KOSTELNIK: Second to the last sentence.

7 Q So what other issues besides expectations of
8 one's natal sex can prompt someone to become
9 transgender, in your opinion?

10 A Well, the issues can be numerous, but their
11 core issue of being female -- I'll stick with that
12 example, is unacceptable, overwhelming. So whether it's
13 being abused or feeling that you're -- made would run
14 away from you or not feeling strong enough to meet the
15 demands that are coming your way, wanting to be
16 physically stronger, even to the point of some trivial
17 thing seeing that I really like the way men look, and I
18 want to feel that way, and I want to smell the way they
19 smell, and different kinds of things. So those are all
20 sub-set, but reacting to the female role, as society
21 defines it.

22 Q Anything else?

23 A No.

24 Q Okay. What about for transgender boys; what's

25 --

1 A It would be the same.

2 Q What are the sex expectations that cause them
3 to say, "I don't want to be a boy any more. I want to
4 be a girl"?

5 A It would be the same, and it may be various
6 male activities that require independence,
7 assertiveness, strength, physical dexterity, and fitting
8 in with males. I have a patient right now who his
9 parents have struggled with the parent role. His
10 grandparents have undermined everything normal about his
11 development, and two years ago, he announced that he was
12 transgender. And it seems to fit in with his withdrawal
13 from the female -- I'm sorry, from the male role. So
14 there are sub-sets of issues there.

15 Q How did the grandparents undermine?

16 A Well, one grandparent overprotective. Any
17 time he had a challenge, they would do things for him.
18 They wouldn't expect kind of independence. His father
19 was a very anxious man who was unavailable, and,
20 actually, I'm doing some therapy with him now; withdrew
21 from his son's experience, and then felt bad about it.
22 His mother similarly had her own issues.

23 Q And you're treating -- are you treating this
24 patient in his -- I'm sorry, the patient now is female,
25 right?

1 A Well, he's moving toward that. I don't think
2 he's engaged in transition. I'm trying to find him
3 another psychiatrist because it's just a better match.

4 Q Okay. Well, I'll use female pronouns where
5 she's transitioning, so But that patient, are you
6 treating her at the Bingham Clinic?

7 A Yes.

8 Q And you're treating her family, her parents,
9 and grandparents?

10 A Well, yeah. It's a totally unique situation.
11 The system is -- has undermined his whole development,
12 so we've had to deal with them. Yeah.

13 Q So yes, you're treating the whole family at
14 the Bingham Clinic?

15 A I've had to have some of our social work
16 clinicians involved. One in particular to try to help.
17 Yeah.

18 Q At -- social clinicians at the Bingham Clinic?

19 A Yes.

20 Q Have you involved any of your -- any other
21 psychiatrists or psychologists in the treatment of this
22 individual?

23 A The social worker was doing it primarily.

24 Q Which social worker?

25 A This person was Karen Miller, was her name.

1 Q And she works with the Bingham Clinic?

2 A Right. With my many other duties, I think the
3 -- there may have been another medication we prescribed.
4 Another psychiatrist said they have to check that.

5 Q A medication for this -- for the female
6 patient; the transgender patient?

7 A Right.

8 Q Is she currently receiving hormone therapy?

9 A No. She'll probably request that. But see,
10 she's in transition. She hasn't even referred to
11 herself as "she" half the time, and hasn't got a female
12 name yet. So it's in process.

13 Q How old is she?

14 A Almost 16, I think, maybe 15, almost 16.

15 Q So what do you base your opinion that abuse --
16 an abusive experience can cause someone to become
17 transgender?

18 A Well, it doesn't cause them to become
19 transgender. It causes them to fear the environment, to
20 fear their own self efficacy, to fear their safety, to
21 fear the ability to negotiate life in meaningful terms
22 where they can take charge of their own life, because
23 they've been victims of various behaviors. And so the
24 interpersonal strength, the self-confidence is a lay
25 term that you need to do that, they often don't have.

1 Q Okay. And so just so I can make sure I have
2 your basis for your opinion that these expectations,
3 these gender expectations can prompt someone to become
4 transgender, are the Finnish study that you referred to,
5 and your experience of seeing three to four patients at
6 Bingham Clinic say that? Is that anything else?

7 MR. KOSTELNIK: Form.

8 A These patients have tremendous anxiety, almost
9 all of them. And when you get -- try to get into that,
10 and explore, which is what I've tried to lay out here,
11 you get some of the sources of that. So what leads to
12 that anxiety, and sense of interpersonal
13 ineffectiveness, and so forth; that's what we look at.
14 Now, that's based on --

15 MS. NARDECCHIA: Move to strike as non-
16 responsive.

17 MR. KOSTELNIK: Well, allow him to finish, and
18 then we can move to strike.

19 MS. NARDECCHIA: Okay.

20 BY MS. NARDECCHIA:

21 Q I'm asking you, though, if there's any other
22 basis for that opinion?

23 A You know how many patients I've told you I've
24 seen. Yeah.

25 Q Okay. Do you believe that a family function

1 can cause someone to -- prompt someone to become
2 transgender?

3 A Family function can lead to all the
4 vulnerabilities that are associated with anxiety,
5 inability to cope, inability to feel that you're strong,
6 self-confident, and the kind of things that lead you to
7 withdraw from life's challenges. Absolutely family
8 function can do that.

9 Q So what kind of family scenario do you think
10 could prompt a person to become transgender; single
11 parents, divorced parents, gay or lesbian parents?

12 A It's all in the interaction. Each of those
13 descriptors -- and you're describing structure, would
14 have to have had life experience that is given to the
15 child. So for a transgender girl to see her mother
16 ineffective or to see her as being mistreated or to see
17 her as being hurt; this is enough for her to in effect
18 say, "I don't want to be a woman."

19 Q And what --

20 A I'm not a woman. Like, I've never been a
21 woman.

22 Q What is your basis for that opinion?

23 A Clinical -- careful clinical observation and
24 interviewing of these patients the last several years.

25 Q Anything else?

1 A I mean, that would be the primary kind of
2 aspect. The other associated one is increasing
3 literature of showing the high levels of dysfunction of
4 these kids and families, and it cannot be explained
5 merely by bias.

6 **Q High levels of dysfunction.**

7 A Read the Finland study.

8 **Q The title -- can you tell me the title again?**

9 A Just -- the author's name is K-I --
10 K-A-I-T-O-L-A. As one example of this. There are
11 others. There's the studies at Harvard by Reisner. That
12 these kids have problems, and they're hurting. And we
13 have to find a way to explain this, and then is the
14 transgender thing an independent event or is it related?
15 And that's the key question that the field doesn't know
16 yet.

17 **Q Okay. Do you recall an article that you**
18 **published entitled "Adolescent Dysphoria Sexual Behavior**
19 **and Spirituality," published --**

20 A Yeah. That's a long time ago. I remember --
21 I think I did that with Dr. Peters. It was a short
22 article. Yeah.

23 **Q In 2008, correct?**

24 A Yeah.

25 **Q What is adolescent dysphoria?**

1 A Well, it's basically adolescent depression.
2 It's a milder term than depression, so it's on the way
3 to depression, if you will. Dysphoria is depressive
4 life, if you will.

5 Q So do you recall stating in that that it is
6 difficult for single parents to structure and limit
7 children?

8 A I'm sure I said it if you've got it there.

9 Q Do you attribute adolescent dysphoria to
10 single parenting?

11 A Of course not.

12 q Do you attribute adolescent dysphoria to
13 being raised by same sex parents?

14 A No.

15 Q Do you remember writing in that article that
16 there is a gender issue and that same sex parents need
17 to "get someone of the other gender to help out"?

18 A I'm sure I wrote that.

19 Q So do you -- you don't attribute, though,
20 adolescent dysphoria to same sex parenting?

21 A No. No. That was -- that statement referred
22 to the observation. Quite common that with same sex
23 parents, they will often find an opposite sex individual
24 friend to help out with parenting tasks.

25 Q Do you think that two parents of the same sex

1 cannot adequately raise a child?

2 A No. Didn't say that. I'm just saying two
3 women, for example, might find an uncle who really is
4 good at football, and their son wants to play football.
5 And so the uncle helps them out.

6 Q What if one of the moms is good at football?

7 A Well, sure. Well, then you wouldn't need the
8 uncle. But if mom isn't, then, you know, then that's
9 the idea there.

10 Q Okay. Is your opinion in this article
11 predicated in part on your religious or other ideology?

12 A I can't remember exactly what I wrote, but no,
13 I wouldn't say so.

14 Q Are any of the opinions you've offered in this
15 case informed in any way by religious or other ideology
16 other than science?

17 A No.

18 Q Can you turn to paragraph 29 of your report,
19 please? And I'd like to direct your attention to the
20 last two sentences of that paragraph. The sentence
21 beginning with, "Some of these factors"; do you see
22 that?

23 A Yes.

24 Q Okay. You mentioned in the next sentence that
25 there is beginning research data, which confirms this

1 **hypothesis. What beginning research are you referring**
2 **to?**

3 A The Kaitola Study, two research studies that
4 are in my bibliography and they basically are entered
5 around this issue: You have two variables, a
6 transgender kid and a great deal of psychopathology.

7 And then the question is: What is the
8 relationship between the two of them? And what I
9 suggest in this paragraph is to say that the reason all
10 these -- and these are big-time things; every
11 psychiatrist would say these are huge problems -- exist
12 because the child was stigmatized or teased or bullied
13 is a gap that's too hard to close, in my view. So,
14 that's what those various factors are. Now, in and of
15 themselves any one thing may not be enough and in our
16 interaction the last hour or two that we've gone back
17 and forth about that so you'll ask about one variable
18 and I'll say, "No. That's not all determinate." But if
19 you mix a lot of things together it can become what we
20 call a psychiatric formulation.

21 **Q And the research that you're referring to, is**
22 **that peer-reviewed?**

23 A Yeah. Now, what I've suggested is my
24 interpretation on this and it's clear that my
25 interpretation is not the interpretation of other

1 people, but --

2 Q So you're talking about your interpretation of
3 this research?

4 A Right.

5 Q Okay.

6 A But it's a question that begs an answer and I
7 haven't seen a good one yet in the literature.

8 Q Okay. Is it --

9 A Except that they've been stigmatized against,
10 which is a problem but not enough to explain this stuff.

11 Q So you just can't fathom that the stigma and
12 the discrimination that transgender youth and
13 adolescents face would cause, for instance, higher
14 suicide rates such high --

15 A Oh no. I think it --

16 MR. KOSTELNIK: Form.

17 A I think it might lead to a higher rate, but as
18 a single variable, as a unitary hypothesis. Yeah. I'm
19 not sure. Now, if the abuse and the stigma were so
20 great -- scratch abuse. Excuse me. That it was just
21 horrific. Yeah. Then maybe. But these are a lot of
22 disorders that are referred to and a lot of symptoms and
23 a lot of suicide and a lot of, you know

24 Q Well, so then it sounds like you disagree with
25 WPATH Standards of Care Guidelines that say,

1 **"Psychiatric occurring conditions in the transgender**
2 **population are typically a result of chronic minority**
3 **distress and stigma rather than internal mental**
4 **disturbance."**

5 MR. KOSTELNIK: Form.

6 A Absolutely I disagree with that. It's just
7 the factual simplistic response and it's the party line,
8 but it's just --

9 Q **And you haven't done any research on this,**
10 **right?**

11 A Well, not except for seeing 15,000 patients
12 that it applies to.

13 Q **But no research.**

14 A No formal --

15 MR. KOSTELNIK: Form.

16 A -- research. No.

17 Q **No clinical studies?**

18 A No.

19 Q **Do you acknowledge that there is a biological**
20 **component to being transgender?**

21 A Well, I think the biological component of
22 temperament and the nature of the child and child's
23 behaviors is an important aspect of biology. Whether
24 there's a biological marker, gene -- why, we don't know
25 this. But, for example -- and I've referred to this --

1 a boy who might be quiet, sensitive, artistic, whatever
2 fits in more easily with girls or similarly a girl
3 fitting in due to some of her biologically mediated
4 temperamental characteristics, that happens a lot. Then
5 the next thing that happens is how you're parented --
6 how parents guide and prompt. And I know very healthy
7 families who've had girls who've had -- want to wear
8 boy's clothes and do boy's things and do -- and they're
9 encouraged to adopt something else and after a few years
10 they recognize one can be a girl and still have
11 "masculine" types interest.

12 Q Do you agree with DSM -- the DSM that
13 "biological factors are seen as contributing in
14 interaction with social or psychological factors to
15 gender development?"

16 A Absolutely. And that's what I just said --

17 Q Okay.

18 A -- in more words than that.

19 Q We've talked a little bit about the
20 persistence, insistence, consistence that's been used in
21 some medical literature and do you agree with WPATH
22 Guidelines that a person's insistence, consistence, and
23 persistence are the most reliable and accurate tools to
24 make the diagnosis of gender dysphoria?

25 A Yes and no. I use too many words. I'll just

1 say no.

2 Q You -- I'm sorry. So you don't agree?

3 A No.

4 Q Why not?

5 A Those characteristics are temperamental
6 characteristics, they're related to how individuals deal
7 with challenges, problems, and if one -- whatever the
8 biologic team might be -- we talked about temperament or
9 predisposition toward transgender. If one continues to
10 insist persistent and is consistently, then maybe that's
11 an indicator that this really is transgender. However,
12 in children, particularly in raising children, we're
13 seeing more and more parents that are very ineffective
14 and I come back to say that earlier. Children are
15 insistent, consistent, persistent about lots of things,
16 whether it's staying up late at night, doing the dishes
17 and doing their homework, I don't want to, I want to
18 turn to -- and to just say that's the prime criteria is
19 pretty weak psychological evidence. But, like most of
20 these guidelines are put together by a group of people
21 who are experienced in the area and they sit around and
22 hammer out the language around a table like this and so
23 that's how it's produced.

24 Q Have you ever been a part of a process like
25 that for creating Standards of Care guidelines --

1 A Yeah. Yeah.

2 Q -- for treatment of transgender patients?

3 A Not transgender, no, but others. I've got it
4 on my CV.

5 Q Does it matter to you if a child says, "I am
6 the other gender" versus "I feel like the other gender"

7 --

8 MR. KOSTELNIK: Form.

9 Q -- as to whether or not --

10 A Well --

11 Q -- would be a good diagnostic criteria?

12 MR. KOSTELNIK: Form.

13 A Yeah. From a standpoint of a
14 psychopathologist, which is one of the things I am.
15 Language is key and so "I am," a much more definitive
16 statement of belief, is much stronger than "I feel like"
17 and so that might be one indicator that they're further
18 along the consolidation of their transgender role, but
19 not the only one and certainly it needs to be followed
20 up.

21 Q Do you use the DSM5 in evaluating patients for
22 gender dysphoria?

23 A Yeah. That's all we have.

24 Q Okay. So you do use it?

25 A Yes.

1 Q Is it your opinion that a child's -- well,
2 strike that. Do you agree with the American
3 Psychological Association's guidance that "Respecting
4 and supporting transgender people and authentically
5 articulating their gender identity can improve their
6 health, wellbeing, and quality of life?"

7 A You mean as a clinician to respect or just
8 anybody?

9 Q Do you --

10 A Could you please --

11 Q -- just do you? Do you agree with the --

12 A Please redre- -- re --

13 MR. KOSTLNIK: Form.

14 Q Yeah. Do you agree with American
15 Psychological Association guidance that respecting and
16 supporting transgender people and authentically
17 articulating their gender identity can improve their
18 health, wellbeing, and quality of life?

19 A Absolutely. And as I mentioned earlier on,
20 it's very important to consider age here. For infancy,
21 toddlers, children, adolescents, and adults a very
22 different kind of situation and children are fluid, they
23 don't know many things, and they need guidance. Adults
24 absolutely need to have those criteria that you've
25 mentioned and supported and encouraged.

1 **Q What about adolescents?**

2 A Well, you know, I think you then get the
3 interview -- (clears throat) excuse me -- you have the
4 experience of the interview where you hear their story
5 and how this developed and how they determined that they
6 were transgender and once it's clear that they're
7 further on down the path and you would support medical
8 intervention, but as you mentioned earlier, many times
9 kids are confused, they change their mind, and the good
10 clinician has the sensitivity to exploring that and not
11 assume that merely because they've declared it that
12 that's the end of the story. If a child declares it the
13 next question is, "Tell me about this; how does this
14 happen?" And there are increasing clinical reports of
15 kids who are saying things -- "I'm glad I was challenged
16 with that. I'm glad I got pushed on that. I'm glad the
17 therapist called me on that because I didn't even
18 consider those things."

19 **Q What are you basing that on, that opinion that**
20 **some kids are -- some youth are glad that they got**
21 **pushed?**

22 A Oh, with self reports, yeah. That are --
23 that's --

24 **Q Which self reports?**

25 A That are on various kids' websites and things

1 that I've seen.

2 **Q Can you describe any or identify any?**

3 A One in particular was on one called "The
4 Fourth Wave." Some are just pointed to my attention and
5 it was fascinating because it was a mother describing
6 her situation of trying to get help for her transgender
7 and all she got was affirmation talk and she said, "I
8 wanted someone to look into this," and her child who,
9 from the time of 12 to 14 -- was adopting this and
10 changed her mind and it's a fascinating description.

11 **Q Any other examples?**

12 A I mean, that -- my point is, I wouldn't --
13 that wasn't even professional literature, but it's out
14 there and the website had 60 hits and responses to this,
15 all from mothers saying the same thing essentially. So,
16 our field needs to find better ways to interview these
17 kids and assess their experience.

18 **Q Would you agree with me that not all children
19 with gender dysphoria are transgender?**

20 MR. KOSTELNIK: Form.

21 A That not all children with transgender --
22 gender dysphoria aren't transgender?

23 **Q Yeah. Would you agree with me that not all
24 children who have or are diagnosed with gender dysphoria
25 are transgender?**

1 A Well, there may be some misdiagnoses, sure.

2 Q Well, gender dysphoria -- there are children
3 who are diagnosed with that but are not transgender;
4 would you agree?

5 A Right. Yeah. And Dr. Brady's mentioned that
6 problem in her clinic now. She's getting all these
7 calls of kids who aren't even transgender. She doesn't
8 know what to do with them.

9 Q And there are some transgender children who
10 many not be diagnosed with gender dysphoria that are
11 living in their affirmed gender, correct?

12 A Run that statement again. I'm sorry.

13 Q There are some transgender children who may
14 not be diagnosed with gender dysphoria because they're
15 living in their affirmed gender?

16 A Exactly. Yeah.

17 Q Okay.

18 A So they're not -- they're happy, they're like
19 the Devreese Study you mentioned, their life is cool --
20 yeah. We don't even see them.

21 Q Okay. Now, you've been talking a lot about
22 children who identify as transgender in childhood later
23 change to match their natal sex and I believe that's one
24 of your opinions; is that correct?

25 A Well, the research shows that particularly the

1 younger the child that happens. In fact, it happens the
2 majority of the time.

3 Q Now, in the research that you're referring to
4 in your report, isn't it true that those studies
5 included children suffering from gender dysphoria who
6 are not transgender?

7 A As the nomenclature is changed, there may be
8 differences between the two groups but I think that's a
9 common response when clearly these kids are not saying
10 they're transgender. The common response is, "Well,
11 they weren't transgender to start with." I'm not sure
12 if that's what you're saying.

13 Q Well, that's what the 2013 review of the
14 studies by Steamsmith showed, right?

15 MR. KOSTELNIK: Form.

16 A I'd have to look at it; I'm not sure. It's
17 generally accepted. That's one of the few things that
18 are accepted in the field is that the majority of
19 children deceased.

20 Q Well, couldn't those studies that you're
21 referring to show that the persisters who remain
22 transgender were of the cov- -- were the transgender
23 covert of the children, when they went back and reviewed
24 it in 2013?

25 A Well, it look -- they were more insistent and

1 intense in their symptoms, correct.

2 Q Right.

3 A If that's what you perceive.

4 Q Yeah. And those who were more insistent or
5 persistent, they had the most intense dysphoria. They
6 continued to be transgender; isn't that right?

7 MR. KOSTELNIK: Form.

8 A The more intense the more likely to continue,
9 right. And the older the more likely to continue,
10 that's correct.

11 Q And didn't the follow-up studies -- or the
12 follow-up to those studies show that the transgender
13 individuals were not -- did not transition until puberty
14 but they would have done so sooner if they had had the
15 chance?

16 A I'm not aware of that. Now, Steamsmith's
17 written a lot of stuff and I just

18 Q It's -- do you know if it's true that the
19 transgender cohort in those studies persisted 100
20 percent?

21 MR. KOSTELNIK: Form.

22 A Which study was this?

23 Q The Steamsmith follow-up.

24 A What year?

25 Q That was -- it was my understanding that that

1 was in the 2013 qualitative review of the study by
2 Steamsmith.

3 A If that captured these intense kids, clearly
4 they're likely to continue but I wasn't aware of the 100
5 percent number.

6 Q And didn't the study count -- wasn't there a
7 methodological flaw because it counted people who left
8 the study and did not respond as the sisters?

9 A I'm not aware of that. Maybe that's --

10 Q Do you know if the people who didn't respond
11 and left the study were 30 percent -- the participants?

12 A That's a high number. Now, this figure is
13 part of the SM5 -- I mean, this approach. We need to
14 have good science and look at that, yeah.

15 Q So your opinions and your report about
16 desistence are only about pre-pubescent children, right?

17 A That's my reading of the literature. Yeah.
18 That the older that you get, the less persistence -- or
19 desistence there is the more persistence, right. I
20 haven't seen anything that reached that 100 percent from
21 Steamsmith but if you select a population pure enough,
22 it could be. There are very few things that are 100
23 percent in medicine, so I don't know.

24 Q Do you have any evidence that adolescents who
25 have reached puberty with gender dysphoria are likely to

1 **desist.**

2 A I wouldn't say likely. There are those who
3 desist, but it's less likely the more one moves toward
4 adulthood.

5 Q **Would you agree that gender dycordant**
6 **teenagers are likely to have cross-gender identification**
7 **for the rest of their lives?**

8 A Likely, I think that's probably true. Yeah.
9 Once you reach teenager years and there's a difference
10 between 17 and 13, yeah.

11 Q **Is that -- does that depend upon when the**
12 **persons go through -- begins puberty, like the 13 to 17**
13 **difference?**

14 A No. I just -- at the time, if you're
15 maintaining this strongly at 17 it's likely to continue.
16 Many 13s, your-all's -- and Drew's an example, they
17 don't even get into it until their 14 or 15, so they're
18 just different in different groups.

19 Q **If you could turn to paragraph 36 of your**
20 **report, please. The first sentence references the**
21 **Standards of Care for individuals with gender dysphoria;**
22 **can you tell me which Standards of Care you're referring**
23 **to in that sentence?**

24 A I was referring to WPATH, I think.

25 Q **Any others?**

1 A You know, they're all somewhat similar,
2 although WPATH are more clear about that period of
3 social transition in psychotherapy before intrusive
4 medical homo-surgery.

5 **Q When was the last time -- oh, I'm sorry.**
6 **Strike that. Have you read the revised WPATH Standards**
7 **of Care?**

8 A They came out a few months ago and I have not
9 looked at them recently. No.

10 **Q Had you looked at them before you wrote your**
11 **expert report?**

12 A Yes. Yeah. There were several versions of
13 them and the one I had available I responded to. But
14 the notions that I refer to there, I think, when I read
15 how they approached psychotherapy it was to facilitate
16 the impending social role transition.

17 **Q You didn't include WPATH in your bibliography,**
18 **right?**

19 A Well, it's there. Maybe I didn't, but I
20 certainly have read it.

21 **Q Okay. Would you agree that WPATH Standards of**
22 **Care recognize the standards for treating gender**
23 **dysphoria by the American Medical Association?**

24 A Yes.

25 **Q And by the American Psychological Association?**

1 A Yes.

2 Q **And by the American Psychiatric Association?**

3 A Yes. They've all taken that as a standard to
4 organize around it.

5 Q **And the American Academy of Pediatrics?**

6 A I'm not surprised. I'm not as sure about
7 that. I know about the other organizations.

8 Q **So are you suggesting in paragraph 36 that you
9 disagree with the WPATH Standards of Care?**

10 A I think I explained it clearly there. I think
11 the -- when you read the Standards of Care, their
12 emphasis is on adjusting on the new gender. In other
13 words, it's already been decided you are what you are
14 and you're going to be moving toward that. My point
15 here is that, as we've discussed earlier, this often
16 occurs in the real world without full expiration of the
17 patient's life, their concerns -- the patient's always
18 affirmed that the idea should be explored thoroughly
19 before they're affirmed. And a phrase I've used
20 frequently and used it in reverse is there is often
21 affirmation without expiration. Or the expiration needs
22 to occur before affirmation, and that's a time-honored
23 way to practice medicine, we diagnose first -- what is
24 going on and then we decide what to do. The feeling I
25 got as you read the Standards of Care is that their

1 decision to do psychotherapy is based on moving full
2 ahead that this is a transgender person. I'm just
3 raising that a lot of times there's not. You've got to
4 make sure.

5 **Q That's -- I just want to be clear. That's**
6 **your understanding of WPATH, right?**

7 A Well, yeah. And I haven't looked at the new
8 standards and I need to.

9 **Q Have you read the recently published version**
10 **of the Endocrine Society Clinical Practice Guidelines**
11 **for Treatment of --**

12 A I've read parts of it, you know. It's, again,
13 a big document. We have -- I think we've talked about
14 six guidelines today but I've seen it. It just came out
15 a couple of months ago.

16 **Q And you can sit here --**

17 A And again, I'm not an endocrinologist so the
18 detail that they get into is about technicalities that
19 I'm not going to work with.

20 **Q Do you consider the Endocrine Society Clinical**
21 **Practice Guidelines to be one of the leading authorities**
22 **on treatment of gender dysphoria?**

23 MR. KOSTELNIK: Form.

24 A Well, it would be the authority of -- for
25 medical treatments for children. Now, in adults,

1 probably would be the same standard. Yeah.

2 Q And the Endocrine Society Guidelines support
3 hormone therapy for treatment -- as treatment for gender
4 dysphoria, correct?

5 A Yeah.

6 Q And are you aware that the Endocrine Society
7 Guidelines state that the terms "biological sex and
8 biological male or biolo -- or female are in-precise and
9 should be avoided"?

10 A The statement that they're in-precise -- I'm
11 sorry?

12 Q Yeah. Are you aware that it states "The terms
13 biological sex and biological male or female are in-
14 precise and should be avoided?"

15 A The Endocrine say that; is that's what you're
16 saying is the new Endocrine Guidelines?

17 Q Are you aware that it states that?

18 A I am delighted that you've informed me because
19 that is unbelievable. Biologic sex. You see everyone
20 knows what that means, it means genetic sex and that --
21 their statement -- read it again -- is in-precise?

22 Q "The terms biological sex and biological male
23 or female are in-precise and should be avoided." So I'm
24 taking that you disagree with that?

25 A Well, endocrinologists -- this is an amazing

1 statement from a physician scientist. Endocrinologists
2 really have no basis in saying that. I mean, they don't
3 know anything more than any other physician. So, but if
4 you say biological sex is in-precise, that's taking the
5 most core foundation from -- I'm assuming they refer to
6 genetics, XX/XY and discarding it and should be avoided
7 and I would say what's -- to use your question, what's
8 the basis? On what basis are anybody saying this?

9 **Q So you disagree?**

10 A Absolutely. Absolutely.

11 **Q Okay.**

12 A And you can put an emphasis on that and they
13 can put an --

14 **Q Okay.**

15 A -- emphasis on the television. That's --

16 **Q Is there --**

17 A -- unbelievable. That's part of why this case
18 is here; that's just unbelievable.

19 **Q Okay.**

20 A Biological sex --

21 MR. KOSTELNIK: Okay. Okay.

22 A -- in-precise?

23 **Q All right. You've made your opinion very**
24 **clear.**

25 A I'll shut up.

1 Q Is your guidance the -- I'm sorry. Let me
2 strike that. Is the Endocrine Society guidance that I
3 just provided to you directly contrary to your opinion
4 that defendant's bathroom policy is "sound" because it
5 separates students by their "biological sex"?

6 MR. KOSTELNIK: Form.

7 A Well, it's a standard way of doing things over
8 centuries in that with the modifications that the school
9 district has made, allowing Drew to go to the bathroom
10 fairly nearby, everyone can go there, it's neutral, it's
11 a compromise with managing the school and Drew's needs.

12 Q Okay.

13 A So --

14 Q So you would agree with me that your position
15 on that is directly contrary to the Endocrine Society
16 Guidelines that I read to you?

17 MR. KOSTELNIK: Form.

18 A No. They made comments about bathrooms?

19 Q You used the term --

20 A Oh, biological sex, biological male.

21 Q Right. And the Endocrine Society is saying
22 that those terms should be avoided so your opinion about
23 the school district's policy directly contradicts
24 Endocrine Society Guidance?

25 A I guess it would. Yeah.

1 Q Okay.

2 MR. KOSTELNIK: Do you mind if we take a quick
3 break?

4 MS. NARDECCHIA: Sure.

5 (OFF THE RECORD)

6 VIDEOGRAPHER: It is 5:04 and we are back on
7 the record.

8 BY MS. NARDECCHIA:

9 Q Dr. Josephson, you're a member of the American
10 Academy of Child and Adolescent Psychiatry, right?

11 A That's correct.

12 Q Okay. Are you aware of their position
13 supporting housing youth in detention and corrections
14 based on their gender identity as the youth defines it?

15 A I'm aware of a number of the statements, but
16 the -- I have a friend who's on the counsel that okays
17 those and I'm not aware of -- I know they're looking at
18 something again in June. They're changing finally, all
19 the time, but that position I'm not aware of, but
20 totally support that. Yeah. That's fine.

21 Q You said what?

22 A I guess they support that from what you read.
23 Yeah.

24 Q Okay. Do you disagree with that position?

25 A To house according to the gender? Is there

1 any age indicated there?

2 Q No. You know what? Here. Let me just mark
3 this as Exhibit 3 so you can look at it.

4 (EXHIBIT 3 MARKED FOR IDENTIFICATION)

5 COURT REPORTER: Thank you.

6 MS. NARDECCHIA: Uh-huh.

7 A I know that's an issue in adult corrections.

8 Q If I understand this, it refers to youth --
9 transgender youth.

10 A Right. Yeah. But they don't rule on anything
11 else besides youth?

12 Q So if you look at the paragraph beginning with
13 the American Academy of Child and Adolescent Psychiatry,
14 I think the third paragraph down.

15 A Right.

16 Q So do you disagree with that recommendation?

17 A Well, it's related to the same issue we're
18 dealing with now, it kind of -- I think the difference
19 there is that rather than a school, is that you all have
20 the same gender in most correctional facilities and
21 they're -- and I just think those things create problems
22 for systems but I -- it's not -- I don't really disagree
23 with it or agree with it. I mean, it's very similar to
24 the issues that we're dealing with here and the main
25 issue is common showering areas and whatnot, I think.

1 But to have gender-neutral bathroom but I don't know
2 about showering. I don't know.

3 Q Okay.

4 A But when organizations make a dictum like this
5 then prison wardens or the correctional facility wardens
6 have all the issues the way the school does here and --

7 Q Okay.

8 A -- I think there's a way to meet an
9 individual's needs but also respect running a prison,
10 too.

11 Q And you're a member of the American Family
12 Therapy Academy, correct?

13 A I was. I'm not a member now.

14 Q When did you stop being a member?

15 A It may -- yeah. I may not have taken that off
16 my CD -- CV. Probably a year or two ago. It just
17 wasn't an organization that was -- you've got to pare
18 down sometimes. I was involved with too many
19 organizations.

20 Q Do you know that they have issued a statement
21 in support of transgender persons and opposing the
22 proposed law because it denies transgender individuals
23 access to bathrooms that match their gender identity in
24 public and charter schools?

25 A I'm not surprised that they would make that

1 ruling -- statement. Yeah.

2 **Q And you -- but you disagree with that**
3 **statement?**

4 A Well, it's with all the others. I mean, I
5 think -- read it for me again.

6 **Q They opposed a law because it denied**
7 **transgender individuals access to bathrooms that match**
8 **their gender identity. That's -- that is contrary to**
9 **your opinion in this case, right?**

10 A Well, yeah. That's what the school district
11 here of Florida is denying Drew, right, access to --

12 **Q That's right.**

13 A Yeah.

14 **Q Right.**

15 A And they've made a compromised position for
16 the neutral.

17 **Q Do you think that these various professional**
18 **groups -- I'm quoting the American Medical Association,**
19 **American Psychological Association, American Family**
20 **Therapy Academy, et cetera -- are endorsing a political**
21 **agenda?**

22 A Small political. It's hard to put a name to
23 it, necessarily, but I think there are clearly political
24 overtones and -- related to all these things. That's
25 why I was denied the rainbow-colored flag in my office.

1 I mean, it's just rough. Why? A number of the articles
2 on my bibliography could not be published -- would not
3 be published by various journals and so those kinds of
4 views are out there. I don't know what the explanation
5 is; political may be one, but

6 **Q Would you agree with me that your views on**
7 **transgender patients are in the minority?**

8 A I would absolutely agree with you on that.

9 **Q Do you think that these various professional**
10 **organizations are employing a radical reinterpretation**
11 **of psychiatry?**

12 A Probably in certain areas, yes. In other
13 areas, no. I mean, the organizations deal with many
14 different issues, so... But I think in the area of
15 human sexuality there's a certain radical agenda going
16 on. Yeah.

17 **Q And you mean with regard to gender identity,**
18 **there's a radical interpretation by all these different**
19 **professional groups?**

20 A Well, I think it's been going on for quite
21 time in different areas. Yeah.

22 **Q And what do you base that on, your belief that**
23 **all these professional groups are having a radical**
24 **interpretation of psychiatry?**

25 A With statements like you just read, that

1 biological sex or biological male are imprecise, and
2 they should be avoided. What -- what is the basis for
3 that? Where does that come from? How do you dismiss
4 centuries of biological functioning understanding in
5 medicine? What drives that? I mean, these are large
6 questions, and I'm not sure I know the answer.

7 **Q With regard to the DSM, you mention in your**
8 **report that "The change from gender identity disorder to**
9 **gender dysphoria is based on a cultural invention**
10 **construct."**

11 A And where did I say that?

12 **Q Yeah. Paragraph 48 of your report.**

13 THE WITNESS: Okay. Oh, I'm sorry. I wrote on
14 that. Thought it was mine.

15 MS. NARDECCHIA: Oh, yeah.

16 MR. PINGGERA: Do you have a clean copy?

17 MS. NARDECCHIA: I think I do.

18 THE WITNESS: I'm sorry.

19 MS. NARDECCHIA: We'll deal with that after the
20 deposition.

21 MR. KOSTELNIK: That's fine.

22 THE WITNESS: Yeah.

23 MS. NARDECCHIA: Okay.

24 THE WITNESS: I -- I -- I just -- yeah. What
25 number?

1 MS. NARDECCHIA: Paragraph 48.

2 THE WITNESS: Yeah. Okay.

3 BY MS. NARDECCHIA:

4 Q Do you see that?

5 A Yes.

6 Q Okay. So the DSM is published by the American
7 Psychiatric Association, correct?

8 A Yes.

9 Q And you're a member of that?

10 A Yes.

11 Q So you believe the American Psychiatric
12 Association changed -- made the change in the DSM to
13 gender dysphoria based on cultural invention?

14 A Strongly influenced by it. Yes.

15 Q What's your basis for that opinion?

16 A How things are expressed, how committees are
17 formed, who -- who gets to express opinions in the
18 committees meetings, just a -- a sense of -- of how
19 these things -- things operate.

20 Q Are you a member of any of the committees
21 regarding gender dysphoria and --

22 A I am not.

23 Q Okay. Were you there for any of the
24 discussions regarding gender dysphoria?

25 A I was at one symposium, I think. I go to a

1 limited number of meetings. I have gone to the APA less
2 often the last several years. I used to be a regular
3 contributor, but I -- I wasn't part of those discussions
4 prior to DSM-5.

5 Q Okay. Are you aware that University of
6 Louisville is currently offering a training for
7 healthcare professionals and medical students
8 certificate program --

9 A Yes.

10 Q -- to provide -- okay. The purpose is to
11 provide knowledge and skills to interact successfully
12 with LGBT patients, correct?

13 A Correct.

14 Q Are you participating in that certificate
15 program?

16 A I'm not right now.

17 Q You're not providing any of the trainings?

18 A No.

19 Q Dr. Christine Brady is planning on doing a
20 session in February regarding treating transgender
21 youth, correct?

22 A This is a session at what meeting?

23 Q This is part of that -- the certificate
24 program at U of L. Are you aware of that?

25 A I'm sure she's on the agenda, yeah, but I

1 didn't know it was in February. No.

2 MS. NARDECCHIA: Okay. I'd like to mark this
3 as Exhibit 4.

4 (EXHIBIT 4 MARKED FOR IDENTIFICATION)

5 MR. KOSTELNIK: Thanks.

6 MR. PINGGERA: Okay. Don't write on this.

7 THE WITNESS: I think the day's getting long. I
8 don't what --

9 MS. NARDECCHIA: We're going to take your pen
10 away.

11 BY MS. NARDECCHIA:

12 Q You can take a second, or let me know when
13 you're ready.

14 A I'm -- I'm ready.

15 Q Okay. Have you ever seen this document, or
16 anything that looks like it, PowerPoint presentation?

17 A No. I haven't seen this.

18 Q Okay. Okay. I'd like to mark this Exhibit 5.

19 (EXHIBIT 5 MARKED FOR IDENTIFICATION)

20 A Okay.

21 Q Do you recognize this article entitled "Gender
22 Dysphoria: A Once Rare, Now Trendy?" Do you
23 see the document that I'm referring to?

24 A Yes. Yeah.

25 Q Okay. If you could please focus on the

1 **Exhibit that I want to ask you about?**

2 A Sure.

3 Q Thank you. Do you recognize this article?

4 A Yes. I think it's related to a radio
5 interview I did last year or something.

6 Q Okay. So you recall being interviewed in
7 August of 2016 by One News Now regarding the transgender
8 Texas kindergarten student?

9 A Yes.

10 Q Okay. And it involved her mother's request
11 for the school -- a school bathroom policy to
12 accommodate her child?

13 A Right. If I remember the child was very, very
14 young, 5, something like that.

15 Q Kindergarten student, right?

16 A Yeah.

17 Q Okay. And you identified yourself in this
18 interview as a psychiatrist with the University of
19 Louisville Bingham's Clinic, correct?

20 A They'd asked me that. Yes.

21 Q Okay. You stated in this interview that, "A
22 kindergarten child could not grasp the concept of
23 transgenderism." Is that right?

24 A Right.

25 Q Okay. So you do not -- well, strike that. Do

1 you believe that a kindergarten age child can know if
2 they are boy or a girl?

3 A They can know if they are a boy or a girl.
4 Yes.

5 Q And you stated, "There must be a 'serious,
6 serious problem in the parent/child relationship,'"
7 right?

8 A Yes.

9 Q Had you interviewed the kindergarten age
10 child?

11 A This was just presented. The child was 5
12 years of age, and the mother wanted to do anything that
13 the child asked --

14 Q Had you talked --

15 A -- or did.

16 Q Have you ever spoken to the mother?

17 A I've not spoken to her.

18 Q Did you examine the child?

19 A I've not examined the child. No.

20 Q Did you evaluate the mother or child?

21 A I've not examined them. No.

22 Q Had you reviewed this kindergarten student's
23 medical records?

24 A Nope.

25 Q Did you know if she'd been evaluated for

1 **gender dysphoria?**

2 A I don't know if she had. No.

3 **Q Did you talk to any of the child's medical**
4 **providers?**

5 A Nope.

6 **Q But you felt qualified to weigh in on this**
7 **child's medical condition in an interview?**

8 MR. KOSTELNIK: Form.

9 A Yes.

10 **Q Okay. Did you --**

11 A Because of the stark nature of the facts of
12 the case.

13 **Q Who gave you the facts of the case?**

14 A Well, just as it was presented to me.

15 **Q Who presented them to you?**

16 A I think the person requesting the interview
17 and said this is what had happened in this Texas case,
18 and the 5-year-old, the mother was making a request to
19 the school district based on a 5-year-old's request or
20 statement and that one needs to guide, explore, think
21 through, but to let a 5-year-old decide the nature of
22 the world in a major thing in school is part of the
23 problem, and I felt very comfortable in saying that
24 because it's sound child psychological development. It
25 always has been.

1 Q Is it sound practice to weigh in on a person's
2 diagnosis publicly without having never spoken or
3 evaluated them?

4 A No. No. And I don't know do I say here that
5 that's what his diagnosis was? He had been diagnosed by
6 someone else.

7 Q You say that this person couldn't be
8 transgender, right, the 5-year-old or the kindergarten
9 age person?

10 MR. KOSTELNIK: Form.

11 A Yeah. I just think we don't know that. I
12 would like to focus more on what children say of what
13 the nature of reality in that, would you believe a 5-
14 year-old about anything much? They do not know concrete
15 operations. They don't know the reversibility of life
16 or death. They -- but the -- the problem here, in my
17 position is, is that the field is believing anything
18 that a child says. A child.

19 Q Okay. And you felt --

20 A Yes. I was just making a general point.

21 Q Okay.

22 A That's all.

23 Q Did you obtain a release from this parent to
24 discuss her child and their family?

25 A No. It's not uncommon. You know, I -- there

1 was no names identified. I didn't speak about this. It
2 was a -- it was an issue presented to me, and I
3 commented on the issue. I also used what doctors do as
4 a therapeutic approach. That is a problem. People
5 should get help with problems, be guided through this.

6 **Q And you advocated to support the school in**
7 **saying they were right to refuse the request --**

8 **A The school --**

9 **Q -- by the mother, right? Isn't that right?**

10 **A That's correct.**

11 **Q Okay. And you also publicly opined in this**
12 **that, "Those suffering from gender dysphoria should not**
13 **be given encouragement." Is that right?**

14 **A Well, I -- I guess encouragement would mean**
15 **affirmation there. They need treatment and certainly a**
16 **5-year-old who says X, Y, Z should not be immediately**
17 **affirmed just because he or she says it.**

18 **Q Do you know if the parent immediately affirmed**
19 **the child, or if that child had been identifying for**
20 **years as being transgender?**

21 **MR. KOSTELNIK: Form.**

22 **A For years. He wouldn't have that many years**
23 **to do it and --**

24 **Q Do you know one way or the other?**

25 **A -- all I know is that the intensity of this**

1 for a mother to -- what was her request? To -- to --

2 **Q Have a bathroom policy.**

3 A -- adopt a transgender bathroom policy for a
4 5-year-old is -- is not good parenting. It's not a good
5 child development, and it's not a good school policy and
6 -- yeah.

7 **Q It's not good parenting to request something**
8 **that your child needs at the school?**

9 A How do you know that the child needs that? You
10 first --

11 **Q Well, how do you know the child didn't?**

12 MR. KOSTELNIK: Form.

13 A Well, child development.

14 **Q Okay.**

15 A A 5 -- a 5-year-old child -- a 5-year-old
16 doesn't know very much.

17 **Q Did you happen to read --**

18 A I -- I --

19 **Q -- the comments on this article, on the**
20 **website, that what people understood you to be saying?**

21 A No. This --

22 MR. KOSTELNIK: Object to the form.

23 A I -- I believe I saw this -- no. I didn't see
24 the comments. No.

25 **Q You state -- you also stated that, "To have**

1 legal processes fight for rights does not do these
2 patients any service." You're referring to the right to
3 access the bathroom that matches one's gender?

4 A Right. The boy needs treatment. The mother
5 needs parent guidance. The mother needs therapy. They
6 need help before having a lawyer fight for a 5-year-old
7 for something that he doesn't even understand.

8 Q And you don't know -- because you never even
9 talked to them or reviewed the records whether they had
10 received any therapy before the --

11 A Well, I hope --

12 Q -- initial request, right?

13 A -- they had.

14 Q Okay.

15 MR. KOSTELNIK: Form.

16 A And certainly they -- they should continue it.

17 Q And you concluded your article by saying,
18 "Your opinion is --

19 A It's not my article. It was an interview.
20 They --

21 Q Okay.

22 A -- talked to me on the phone.

23 Q You concluded your interview, or you said in
24 the interview that "Gender dysphoria is 'becoming
25 trendy.'" Is that right?

1 A That's correct.

2 Q So is it your opinion that patients request to
3 be diagnosed with gender dysphoria because it's trendy?

4 A No. I didn't say that. I'm just saying it is
5 becoming, and even more since that was, it's even more
6 so now, and it will be even more so as we see this
7 diagnosis skyrocket and balloon, and it's a problem for
8 psychiatry and to some extent psychology.

9 Q Who has been diagnosing patients with gender
10 dysphoria because it's trendy?

11 A I don't think anyone does that by intent. The
12 patients come with the symptoms. In fact, the patients
13 often come with a diagnosis, and my point in this
14 testimony has been that all too often people affirm
15 without exploring first.

16 Q Do you disagree with WPATH guidelines that,
17 "Advocacy on behalf of gender dysphoric children is
18 'particularly important given harassment they may face
19 at school?'"

20 A Well, again, the age is important. I think
21 harassment occurs most frequently in adolescence, and
22 there should be advocacy and support for them. That's
23 true. Absolutely.

24 Q But you disagree that children should also get
25 advocacy who are gender dysphoric?

1 A The child needs effective parenting. They
2 don't -- they don't -- they need parents who -- who know
3 how to effectively parent. They don't need an advocate,
4 a lawyer, to discuss a 5-year-old issue.

5 **Q Do they need their parent to advocate for them**
6 **when they're being mistreated?**

7 A A parent should advocate for them, and, in
8 this case, I think the mother was -- was doing what she
9 thought was best, but, you know, there was a comment
10 that he would want to die and go to heaven and so forth
11 like this. Children are in, what has been known for 50
12 years, preoperational thinking. This is magical
13 thinking.

14 **Q Okay. I'd like to turn, now, to your -- the**
15 **comments you made in the Panel at the Heritage**
16 **Foundation Panel. Did you compare the idea of parents**
17 **supporting their gender -- their child's gender identity**
18 **as abuse?**

19 A No.

20 **Q Do you think it's abuse to support your**
21 **child's gender identity?**

22 A No.

23 **Q Do you think it's neglect?**

24 A I think it borders on neglect because it
25 avoids fundamental parts of -- that are necessary for

1 healthy parenting.

2 Q Have you ever reported a parent affirming
3 their child's gender identity to Protective -- Child
4 Protective Services for being neglectful?

5 A No. And I'm not going to either.

6 Q Do you believe a medical provider affirming
7 the child's gender identity is neglect?

8 A No.

9 Q You also gave an example of a child of 8 or 9
10 expressing she is no long female, and you said, "Why
11 should we listen to a 9-year-old?" Do you recall saying
12 this?

13 A I think I said something like that.

14 Q Do you think medical providers should ignore
15 9-year-old's who express strong desire to be of the
16 other gender or an insistence that they are the other
17 gender?

18 MR. KOSTELNIK: Form.

19 A They should not ignore that. They should
20 explore before affirming. They should understand this
21 and not immediately say, well, the 9-year-old said this,
22 so it can be verified.

23 Q So you should listen to the 8 or 9-year-old?

24 A Absolutely and understand this, but not --
25 give it time to explore this.

1 Q In fact, doesn't WPATH Standard of Care state
2 that, "Mental health professionals should not dismiss or
3 express a negative attitude regarding indications of
4 gender dysphoria?"

5 A What age a patient are we talking about?

6 Q I don't know. That's WPATH, page 15. Do you
7 agree with that?

8 A Well, it depends on the age of the -- if -- if
9 a 3-year-old or a two-and-a-half said this, I would
10 dismiss it because it would be ludicrous to try to
11 engage in a cognitive statement when the child has no
12 ability to do this.

13 Q So you would dismiss a --

14 A If the child is seven --

15 MR. KOSTELNIK: Let him finish.

16 A If the child is 17, then one would engage in a
17 very different type of -- of -- and most parents who are
18 effective have to dismiss certain things, even some
19 things that are insistently -- persistently and
20 consistently requested.

21 Q I'm talking about mental health professionals.

22 A Right.

23 Q Is there -- what age is enough that you should
24 not dismiss or express a negative attitude regarding
25 indications of gender dysphoria?

1 A You should never express a negative attitude.

2 Q Okay. What about the --

3 A Saying no is not a negative attitude.

4 Q Okay. What about dismissing?

5 A Dismissing what? I'm sorry.

6 Q You said, "You would dismiss if a 2 or
7 3-year-old expressed indications of gender dysphoria."
8 Is there a minimum age at which you would stop
9 dismissing that?

10 A Everything is a transition in development. You
11 would gradually listen to more and more. Preoperational
12 thinking, and what that means is magical kind of
13 thinking and ability to kind of make sense of the
14 irreversibility of death, the permanence of -- of these
15 kinds of decisions and, indeed, gender. A child under
16 the age of 6, 7, 5, their mind isn't there yet, and the
17 parent needs to think for them. That's child
18 development.

19 Q In your panel discussion, you also discussed,
20 "The patient you saw in early October, who you said
21 wanted to be called Matt said he identified as male." Do
22 you remember talking about that patient?

23 A Yes.

24 Q Okay. You referred to Matt as Madeline in the
25 speech and used female pronouns, right?

1 A I may have done that. Yeah.

2 Q Is -- I'll use the way you identified the
3 patient. Is Madeline someone you're currently treating?

4 A I treated her --

5 Q When?

6 A -- in -- for a while and then we did shift to
7 her Matt. She was unsure for a while and then became
8 more sure in her identify, and I shifted to calling her
9 Matt. Her name was Madeline, and we shifted to Matt.

10 Q But in your Heritage Foundation presentation,
11 you referred to her as Madeline in this, didn't you?

12 A I guess I did.

13 Q So this person is transgender and now is male
14 and goes by Matt; is that right?

15 A Yes.

16 Q Where did you treat this person?

17 A This person was at Buckhorn.

18 Q And you shared in your -- the panel discussion
19 that Matt had suffered abuse, correct?

20 A Very badly. And she used the phrase, "You
21 know, all the bad things that have happened to me in my
22 life have happened to me as Madeline, as a girl, and I
23 want to be as far away from that as I can."

24 Q You said you continued to do some therapy with
25 Matt. Is that therapy over?

1 A She was discharged ten days ago. Yeah. So
2 it's over. She's referred to a psychotherapy clinic
3 near her home, and the family was reunified. She was in
4 foster care for almost a year, and we worked a great
5 deal together to reunite her with her mother and her
6 sister, which was very gratifying.

7 Q Did you get Matt's permission to use his name
8 publicly in the Heritage Foundation presentation?

9 A I did not. I didn't have any other
10 identifiers of this, so that's what I said.

11 Q Did you get a release from Matt or his
12 parents?

13 A I did not. She only had one -- one parent.

14 Q Okay. Okay. You also mentioned in this
15 panel, you gave an example of a child saying, "Mom, I'm
16 a boy," and you said you don't affirm a bad idea.

17 A Right.

18 Q So the bad idea meaning affirming that child
19 saying that they're a boy, right?

20 A The bad idea is saying a child is a boy when
21 he's not a boy.

22 Q Okay. And you mentioned that one of the
23 therapists in the clinic either disagreed with you on
24 this, and her response to you is, "I don't need to judge
25 this boy." Who was the therapist you're referring to?

1 A I'm not going to use that name. That's
2 privileged information, I think.

3 Q **The name of the therapist at your clinic?**

4 A Right. Yeah. You're just talking about
5 getting releases, and I don't have her release to talk
6 --

7 Q **But she -- no. I'm sorry. Just to be clear,**
8 **I'm not asking about the patient. I'm asking about the**
9 **therapist. You said that --**

10 A I know. And I'm saying the same thing. I
11 protect my employees. I don't think that I'm going to
12 release that name.

13 Q **Okay. Well, just so you know, we may raise**
14 **this issue with the court and --**

15 MR. KOSTELNIK: Can we go off record?

16 MS. NARDECCHIA: Sure.

17 MR. KOSTELNIK: Okay.

18 VIDEOGRAPHER: Off the record at 5:33.

19 (OFF THE RECORD)

20 VIDEOGRAPHER: It is 5:36, and we are back on
21 the record.

22 BY MS. NARDECCHIA:

23 Q **So do you -- are you sticking with not wanting**
24 **to disclose who that therapist was?**

25 A No. That's fine. I was -- I was instructed

1 that legally, that's fine. Her name is Karen Miller.

2 Q Okay. Is she the social worker that you
3 talked about earlier?

4 A Isn't that what we're talking about now?

5 Q Yeah. Is she a social worker?

6 A Karen Miller is a social worker, but who did
7 we talk about earlier? What -- what --

8 Q I just remember that name and that's fine. So
9 Karen Miller is a social worker at Bingham Clinic?

10 A Right. No. Actually, she -- she was the one
11 that worked with the male transgender that I'm referring
12 to another psychiatrist. Yes.

13 Q Okay. Okay. So she is a therapist, and you
14 said -- disagreed with you about that, right?

15 A Well, I can't remember the exact context, but
16 I was speaking as a physician, and she made the comment
17 that -- that, "I'm not here to judge him." I forget
18 what the issue was, and I tried to help her see, as a
19 clinician, as a doctor, we do that all the time. We
20 call it diagnosis. You don't judge in a moral sense, in
21 a pejorative sense, in a non-affirming sense, but we
22 judge in what are the facts of it in that just as I've
23 described here, you -- if a 3-year-old says that they're
24 a girl or a boy and they're not, you make a judgment, is
25 this something that I want to believe or not.

1 Q Okay.

2 A That's -- and I can't even remember the issue.
3 I think it may have had to do with a transgender boy,
4 but it was a couple of years ago, and I think --

5 Q Okay. Did you recommend during the Heritage
6 Panel that, "The best treatment for children in
7 adolescence with gender dysphoria is to force them to
8 'push through their negative feelings and accept their
9 natal sex?'"

10 A Exploration before affirmation, that to
11 explore anything that was difficult, painful. Push
12 through gives a wrong kind of implication, but that to
13 grapple with that and that was the idea there.

14 Q Okay. And you said -- one of the things that
15 you said was, this is a quote, "The psychiatrist has a
16 worldview, and it interacts with the patient's
17 worldview." And then you said, "Whether it's prejudiced
18 or not, we have certainly who we are and how we come to
19 see things." In that, were you acknowledging that you
20 have prejudiced against people who are transgender?

21 A No. I have a view of how this condition
22 develops and how we should treat it, but I have no
23 prejudices, as much as humanly speaking, against anyone.
24 I treat all my patients the same.

25 Q Okay. I'm just -- okay. Do you have a

1 worldview about transgender people that impacts how you
2 treat them?

3 A Not about transgender people. A worldview
4 about suffering and how we heal it and help it, and many
5 of these kids are suffering and argue they're all
6 suffering, and their parents are confused.

7 Q In your -- one of the reports you submitted in
8 the Illinois case, you wrote that there were three types
9 of transgender people. The first -- and so I'm going to
10 read you the quote that I wrote out here, okay? "The
11 first group is determined by punitive, biologic
12 abnormalities, and the second comprise of those
13 biopsychosocially determined psychiatrically
14 vulnerable."

15 A Right.

16 Q "The third type with no impuric understanding
17 as yet appears to be the culturally chic --

18 A Right.

19 Q -- which is driving an increased incidents in
20 some settings."

21 A Yeah.

22 Q Is that -- do you still have that opinion?

23 A Read -- read the first -- the first one I
24 said, what I said about the biological punitive.

25 Q "The first group --

1 A Oh.

2 Q -- determined by punitive biologic
3 abnormalities."

4 A Right. And in adolescence biopsychosocial.
5 Yeah. Actually, I -- I do, and to use different
6 language the -- it comes back to there are probably some
7 kids who are the classic transgender -- transgender so
8 maybe a 3 or 4-year-old kid says I'm a boy, a girl, vice
9 versa, and, in fact, he's responding to something
10 internal, that's the punitive biologic, and it persists
11 through his development, and he says it when he's 9.
12 He's says it when he's 15, and he says it when he's 22,
13 and those are fascinating cases. I think they're in the
14 minority, but they're probably there, and they would be
15 what the kind of real transgender would be. The -- the
16 -- the 5-year-old kid who wants to go to heaven, and his
17 mother wants a different bathroom for him, who knows.
18 And many children of that age or 3, that's not what
19 we're talking about. Kids are coming up with that, and
20 parents aren't guiding them, but there are young
21 children and that would be one. And then the
22 adolescence ones are the ones, Madeline/Matt deeply
23 troubled, and the ones with the Kaitola Research and
24 Rychener Research, and they come with all these kinds of
25 things. Biopsychosocial messes, if you will, and we

1 need to disentangle them, and what is the relationship
2 of the transgender position view to all these other
3 things. And then, finally, I don't see too many of
4 these. I think these are upper -- upper social economic
5 educationally advantaged, maybe the DeVry Studies Group,
6 and, you know, these are the kids that when you -- when
7 you talk to higher level high schools, higher level
8 meaning very competitive smart kids, transgenderism is
9 just all over the place. And it's -- it's trendy for a
10 different reason. That's, I guess, where I said with
11 it.

12 Q Yeah. I thought you meant trendy, so
13 culturally chic here, you're basically saying there's a
14 group of transgender people that are being transgender
15 because it's culturally chic; is that right?

16 A It's cool. Yeah.

17 Q What percentage of people who are transgender,
18 would you say, are transgender because it's culturally
19 chic?

20 A I've no idea. I think it's -- it's a minority
21 number, but it's -- it's -- and this thing's involving,
22 too, so rapidly.

23 Q How did you come to that? Like, what
24 scientific or medical basis do you have that there are
25 some people who are transgender because it's culturally

1 **chic?**

2 A Well, there's --

3 MR. KOSTELNIK: Form.

4 A -- no science in this. The science is
5 unsettled. Talking with clinicians, doctors, annual
6 meetings, people, psychiatrists saying -- you know,
7 psychiatrist consulted this school, and, you know, the
8 -- one teacher says, you know, I've got 15 girls in the
9 class, a girl school, and 13 or 12 of them are
10 transgender, and in the -- in the groups we have, that's
11 all they talk about. That's -- that's what I'm
12 referring to. So there's no science or data on yet,
13 but...

14 **Q I just have a couple of minutes. Let me ask**
15 **you a few more questions. Are you currently a member of**
16 **the Christian Medical and Dental Association?**

17 A I think so. If I remember to pay my dues,
18 yes.

19 **Q You didn't list that on your CV.**

20 A It's not on there?

21 **Q No. Was there a reason?**

22 A I don't know if there's a -- a reason. I
23 haven't put all the organizations on there, and I think
24 it's for some people, it's a needless flashpoint, but I
25 have no apology to identify. Been a member of that

1 group for quite some time.

2 Q Okay. Let me just -- this is one exhibit I
3 want to make sure I ask you about and then I think I'm
4 done. This is Exhibit --

5 COURT REPORTER: 6.

6 Q -- 6. Thank you. Have you ever seen that
7 before?

8 (EXHIBIT 6 MARKED FOR IDENTIFICATION)

9 A Yeah. I've seen this.

10 Q You've read through it?

11 A It's been some -- some time since I read it,
12 but

13 Q Okay. Did you have any role in drafting or
14 writing this?

15 A I did not have any role in drafting or writing
16 this.

17 Q Do you agree with this epic statement by the
18 Christian Medical and Dental Association?

19 A I agree with the -- with the -- the crust of
20 much of what the CMD organization does, but I'd have to
21 go through this line by line.

22 Q Well, this is -- I would like you -- if you --
23 if there's any part that you disagree with to please
24 tell me.

25 A I'm going to have to read it.

1 Q Okay. I really would like an answer to that
2 question, then, and I can end there.

3 A So you want to know if I disagree with
4 anything here?

5 Q Yeah.

6 A Okay. I would disagree with -- with the
7 statement that, "Attempts to alter gender surgically or
8 hormonally for psychological indications are medically
9 inappropriate." Many times they are. Sometimes they're
10 not. That's -- that's a -- a definitive statement that
11 -- that I would disagree with. So that when the
12 organization says, "They oppose gender transition,"
13 that's too simple. I think in some cases, gender
14 transition should be supported.

15 Q You know what? I know I've asked you to do a
16 lot here, but maybe I can just focus you on --

17 A Yeah. So the main issue is the -- the first
18 paragraph --

19 Q All right.

20 A -- I would disagree with.

21 Q Okay.

22 MR. KOSTELNIK: Yeah.

23 Q I think -- I just think --

24 A But this is a loaded document --

25 Q Okay.

1 A -- that I think would -- took people three
2 years to do, so I'm trying to be serious, but go ahead.

3 Q Yeah. No. And I don't want us to all have to
4 sit here, but --

5 A Yeah.

6 Q -- overall, would you say that you agree with
7 the majority?

8 A Well, the first part, the majority of that.
9 Yeah. I -- the part of -- of flatly saying medical
10 transition is not supportive of -- you know, for some
11 cases, certainly kids need this and benefit and then
12 adults, too. The challenges are determining who. Is
13 there something else here you want to look at?

14 Q Just let me ask one question. Sorry, just one
15 last question: Do any of your personal religious
16 beliefs influence any of your opinions in this case?

17 A None whatsoever. There's no belief that this
18 is just science we're talking about and human
19 development and psycho pathology.

20 MS. NARDECCHIA: Okay.

21 MR. KOSTELNIK: All right.

22 MS. NARDECCHIA: I'm sorry. I really wanted an
23 answer, but...

24 MR. KOSTELNIK: I understand.

25 MS. NARDECCHIA: Okay.

1 CROSS-EXAMINATION

2 BY MR. KOSTELNIK:

3 Q Okay. So I'm sorry, I'm going to jump around
4 a little bit. I'm just going off my notes, Doctor.

5 MS. NARDECCHIA: Oh, do we need to go -- I
6 think we need to go off the record.

7 MR. KOSTELNIK: Yeah. That's fine.

8 VIDEOGRAPHER: Well, let's -- if you'd just --
9 I know it's kind of hard because he's talking and
10 you want to look, but --

11 THE WITNESS: Okay. Just going to get -- get -

12 -

13 VIDEOGRAPHER: -- you kind of want to, like,
14 look at the camera.

15 THE WITNESS: I'll look at you. Oh.

16 VIDEOGRAPHER: Yeah.

17 THE WITNESS: Well, I'll just look at you out
18 of the corner of my eye, okay?

19 VIDEOGRAPHER: Okay. Whatever's easier, yeah,
20 but -- yeah.

21 BY MR. KOSTELNIK:

22 Q So I apologize if I jump around a little bit.
23 I'm just going off my notes. Are you a lawyer, Dr.
24 Josephson?

25 A No. I'm not.

1 Q Are you a judge?

2 A No.

3 Q Have you ever gone to law school?

4 A No.

5 Q Okay. So is it fair to say that if
6 plaintiff's counsel ask you to render some sort of legal
7 conclusions throughout this deposition, you're not
8 qualified to do that?

9 A That would be correct.

10 Q If an individual changes his birth
11 certificate, his or her birth certificate, or his or her
12 driver's license, does that change their biological sex?

13 A No.

14 Q Are you aware of any long-term studies that
15 show that allowing a transgender individual to use the
16 bathroom of their gender identity is a necessary
17 treatment for gender dysphoria?

18 A No.

19 Q If a bathroom was three minutes away from you,
20 would you consider that to be close proximity?

21 A Yes.

22 MS. NARDECCHIA: Just give me a second to
23 object if I need to before you answer, if you don't
24 mind? Okay.

25 MR. KOSTELNIK: That's fine.

1 BY MR. KOSTELNIK:

2 Q Earlier in this deposition, you testified that
3 Drew Adams was allowed to use the bathroom for a month.
4 Do you know if he was allowed to use it?

5 A Allowed means someone gave him permission. I
6 -- I don't know that.

7 Q Okay. As far as you know is that he did use
8 it?

9 A Yeah. Yeah.

10 Q Would it be distressing for a boy -- scratch
11 that. Could a boy find it distressing to be seen using
12 a urinal by someone of the opposite sex?

13 A Sure.

14 Q And a few times you testified throughout that
15 when an individual goes through a full transition, they
16 should be affirmed; is that correct?

17 A Right. Once they've completed the process,
18 they -- they should be affirmed and supported as a human
19 being individual who has made these choices and is now
20 living with them.

21 Q And when you say -- do you understand that to
22 mean an individual who has undergone "bottom surgery?"

23 MS. NARDECCHIA: Objection. Leading.

24 A Any kind of surgery. Once they said, I'm
25 going to be female or male, and I am that and was

1 formally another sex, one needs to respect that, that
2 the decision's complete. Even there are many
3 indications, a good number, where people, then, do it
4 back it again. It's an extraordinarily complex thing.

5 **Q When you formed your opinions for this case,**
6 **were you relying on your experience?**

7 A Right. My 41 years' experience. Yeah.

8 **Q Okay. Including some of the documents listed**
9 **in your bibliography?**

10 A Right. Yeah. Literature, patients, teaching,
11 whatever.

12 **Q Would you be required to get permission from**
13 **your employer before disclosing patient records to a**
14 **third party?**

15 A Absolutely. They're not my records. They're
16 theirs.

17 **Q And are some of those transgender patient**
18 **records with your previous employers?**

19 A Almost certainly they are. Yeah.

20 **Q Can an individual be bullied or discriminated**
21 **against because he's overweight?**

22 A Happens all the time.

23 **Q What about because of the way he or she**
24 **dresses?**

25 A Yes. Multiple ways to be bullied or teased.

1 Q Not just because of someone's gender identity,
2 correct?

3 A Correct.

4 Q Okay. I'm showing you what's been marked as
5 Plaintiff's Exhibit 1 on page 18. Do you recognize
6 that?

7 MS. NARDECCHIA: Excuse me. Hold on. Let me
8 find the exhibit. Thank you. Thank you.

9 Q Do you see that top slide?

10 A Yes.

11 Q And it says that at age 4, gender identity is
12 stable and constant.

13 A Right.

14 Q Is it a possible for an individual's gender
15 identity to be unstable at or after the age of 4?

16 A Sure. It's possible. This is actually a
17 general statement of what anything about the
18 personality. It's -- it's more stable 3, 4, 5, but
19 things can change.

20 Q Do you believe -- do you agree that the rights
21 of a transgender individual has to be balanced with the
22 rights of a cisgender individual?

23 A Absolutely.

24 Q Will you look at the new WPATH standards
25 before trial?

1 A Yes.

2 MR. KOSTELNIK: I believe that's all I have.

3 MS. NARDECCHIA: Okay. Since this is an
4 expedited situation, how many days do you think you
5 need to review your transcript?

6 COURT REPORTER: Is this on the record?

7 THE WITNESS: When will I get it?

8 MS. NARDECCHIA: We can -- you know what, we
9 can just go off the record.

10 MR. KOSTELNIK: Yeah. I think that's fine.

11 MS. NARDECCHIA: Okay.

12 VIDEOGRAPHER: Okay. It is 6:00, and we're off
13 the record.

14 (DEPOSITION CONCLUDED AT 6:00 P.M.)

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1 CERTIFICATE OF REPORTER

2 COMMONWEALTH OF KENTUCKY AT LARGE

3
4 I do hereby certify that the witness in the foregoing
5 transcript was taken on the date, and at the time and
6 place set out on the Title page hereof by me after first
7 being duly sworn to testify the truth, the whole truth,
8 and nothing but the truth; and that the said matter was
9 recorded by me and then reduced to typewritten form
10 under my direction, and constitutes a true record of the
11 transcript as taken, all to the best of my skills and
12 ability. I certify that I am not a relative or employee
13 of either counsel, and that I am in no way interested
14 financially, directly or indirectly, in this action.

15
16
17
18 

19
20
21
22 MEGAN BROWN,

23 COURT REPORTER / NOTARY

24 COMMISSION EXPIRES ON: 09/25/2018

25 SUBMITTED ON: 11/30/2017

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION**

DREW ADAMS, et al.,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS
COUNTY, FLORIDA, et al.,

Defendants.

No. 3:17-cv-00739-TJC-JBT

**[PROPOSED] ORDER GRANTING PLAINTIFF’S MOTION TO PRECLUDE DR.
JOSEPHSON FROM TESTIFYING AND
OFFERING ANY PURPORTED EXPERT OPINION IN THIS MATTER**

This matter comes before the Court on the Motion to Preclude Dr. Josephson from Testifying and Offering any Purported Expert Opinion in this Matter, filed by Plaintiff Drew Adams (“Drew” or “Plaintiff”), by and through his next friend and mother, Erica Adams Kasper, by and through their attorneys.

Having reviewed the papers filed in support of and in opposition to this motion, having heard arguments from counsel, and being fully advised, the Court hereby **GRANTS** Plaintiff’s motion for good cause shown.

Accordingly, it is hereby **ORDERED** that:

Dr. Josephson is precluded from testifying or otherwise offering any expert opinions at trial in this matter.

DONE AND ORDERED in Jacksonville, Florida this _____ day of
_____, 2017.

Hon. Timothy J. Corrigan
United States District Court Judge