EXHIBIT

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(Deposition of Bernard Hudson, M.D.)

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, individually and on behalf of his patients, DAVID H. PICKUP, LMFT, individually and on behalf of his patients, and SOLI DEO GLORIA INTERNATIONAL, INC., d/b/a NEW HEARTS OUTREACH TAMPA BAY, individually and on behalf of its members, constituents and clients,
Plaintiffs,
vs.

CITY OF TAMPA, FLORIDA,

Defendant.

CASE NO: 8:17-cv-02896-WFJ-AAS

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DEPOSITION OF: BERNARD HUDSON, M.D.
TAKEN: PURSUANT TO NOTICE
COUNSEL FOR DEFENDANT

DATE: July 30, 2019

TIME: 9:00 a.m. - 3:16 p.m.

LOCATION: Burr & Forman, LLP
201 North Franklin Street
Tampa, Florida

REPORTED BY: ELSA M. HERNANDEZ, FPR
Notary Public

APPEARANCES:

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Appearing on behalf of the Plaintiffs

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Appearing on behalf of the Defendant

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EXHIBITS

THE COURT REPORTER: Would you raise your right hand, please. Do you swear or affirm the testimony that you are about to give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

BERNARD HUDSON, M.D.,

the deponent herein, being duly sworn under oath, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Please state your full name, sir.
A. Bernard O'Grady Hudson, III.
Q. Where do you reside, sir.
A. Franklin, Tennessee.
Q. What do you -- do you do work?
A. No.
Q. Are you retired?
A. Yes.
Q. What are you retired from? What did you do before you retired?
A. I was a physician.
Q. What kind of physician?
A. My specialty was psychiatry. My subspecialty was child and adolescent psychology.
Q. For how long did you practice psychiatry and

in particular child and adolescent psychiatry?
A. From 1982 to midnight December 31st, 2018.
Q. Okay. I have your declaration, and it tells me all about your background, but just for the record, would you bring us up to date as to your educational matriculation, starting with college.
A. I attended the University of California, San Diego from 1975 to 1979. I was accepted into medical school at Loyola University, Cardinal Stritch School of Medicine in Chicago from July 1st, 1979, until June 30th, 1982. I then completed an internship and residency at the Medical College of Wisconsin in Milwaukee from 1982 until 1985. And then on July 1st, 1985, I attended the University of California, Davis, School of Medicine, a two-year fellowship, and I finished that June 30th, 1987.
Q. So do you have an MD degree?
A. Yes.
Q. Do you have any other, like a Ph.D. as well?
A. No.
Q. Are you licensed in the state of Tennessee to practice psychiatry and medicine?
A. Yes.
Q. And that license is current?
A. Yes.

Electronically signed by Elsa Hernandez (401-364-747-9923)

Q. Where else are you licensed?
A. I retired officially from California, and that license expired under the retirement March 31st, 2019.
Q. So currently you are licensed to practice only in Tennessee, an active license?
A. Correct.
Q. I note from our discussion before this deposition started that you returned to Tennessee a couple of years ago, approximately; correct?
A. Yes.
Q. And where did you return from?
A. We lived in Tarzana, California.
Q. How long did you live in California?
A. November of 2000 until November of 2017.
Q. And did you practice medicine in Tarzana?
A. I practiced medicine in Los Angeles.
Q. You lived in Tarzana but practiced in --
A. In Los Angeles and other cities around in Los Angeles County and one place outside of Los Angeles County, in Ventura County.
Q. Did you have a private practice?
A. Not when I went to Los Angeles.
Q. How did you practice medicine then? What was your medium?
A. I went to Los Angeles to work with Dr. Doris

Soghor, who was the supervisor of the juvenile justice program, and I worked with her from November of 2000 until August of 2011 and -- which point she retired, and then Christopher Thompson, a medical doctor, a psychiatrist, took over for her, and I worked under him from August of 2011 until I retired November 2018.
Q. How do you spell Dr. Soghor's last name?
A. S-O-G-H-O-R.
Q. And was there a specific reason why you wanted to work with Dr. Soghor?
A. Yes. When I had -- the reason I did my fellowship in -- at UC Davis is that an individual named Robert Dorn was a psychiatrist there and a child adolescent psychiatrist. He had worked with Anna Freud and Melanie Klein at the London Clinic, and he had been psychoanalyzed by Melanie Klein, and I wanted to work with him and know him and get consultation from him.
He had left Los Angeles. He had worked with Dr. Soghor's husband, who is a psychoanalytic physician, and so one thing led to another, and I called her in August of 2000. We had a great conversation, and I had finished my work with the Department of Justice Civil Rights Division. We had been investigating Georgia and Louisiana juvenile facilities, and they had said that they were about to

investigate Los Angeles County Juvenile Hall. So --
Q. They being the Department of Justice.
A. Department of Justice. And so I went out there to work and to see what they did, and then I was designated the instructor/teacher for probation, mental health services and health services.
Q. By DOJ?
A. By DOJ and by LA County.
Q. And that is how you hooked up with Dr. Soghor eventually?
A. Yes.
Q. How long did you work for the Department of Justice, sir?
A. It was while I was in Tennessee, and I believe it was from 1997 until 2000.
Q. And I noticed from your declaration that you were an adjunct professor at Vanderbilt; is that correct?
A. No. I was an assistant professor.
Q. Assistant. Okay. And when was that, sir?
A. August of 1995 until August of 2000.
Q. Was that a full-time position?
A. Yes.
Q. And that was before you went with DOJ?
A. It was while I was With the Department of

Justice.
(A discussion was held off the record.)
BY MR. WILLIAMS:
Q. All right. So you were with DOJ while you were also an assistant professor at Vanderbilt?
A. Yes.
Q. And in your tenure, during your tenure as an assistant professor of medicine at Vanderbilt, did you teach psychiatry?
A. Yes, I taught psychiatry and child and adolescent psychiatry.
Q. Did you work with residents?
A. Yes.
Q. Did you actually teach classes to the medical students prior to residency?
A. Yes.
Q. You were out in California for a number of years working with Dr. Soghor and Dr. Thompson. Was there a specific area that you focused on during that part of your professional career?
A. There were three -- three items. My primary job, which was my focus, was the psychiatric treatment of juveniles in confinement. LA County has the largest juvenile justice program in the country. They have three juvenile halls that can hold up to 600 to 700

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youth. They have 14 to 15 camps that can hold up to 2,000 or 3,000 youth. So that was my primary job. And within that job, I was teaching courses that were four hours and eight hours, to probation staff, to health services staff, and to mental health services staff.

My second position was I was working in the community and I was working at a residential facility and a place downtown in LA.

And in the third position, I occasionally flew back to Tennessee to take on forensic cases, primarily out of Nashville and Knoxville. I think I did three or four of those cases. They were criminal cases, and I had picked up those cases while I was at Vanderbilt School of Medicine, and then I continued them while I was in Los Angeles for a short period of time.

Q. All right. Under roman numeral II of your primary declaration -- when I say primary, I'm not talking about the rebuttal declaration.

In paragraph 10, which is under roman numeral II, Summary of Opinions, you state in your declaration, "My opinions regarding the lack of scientific justification for Ordinance 2017-47," which is the ordinance which is the subject matter of this lawsuit, "may be summarized as follows." And then you go down seven separate paragraphs to finish that concept.

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Now, when were you retained to be an expert witness in this case, Doctor?

A. March of this year.

Q. March of 2019?

A. Yes.

Q. And who retained you, or who contacted you?

A. Vernadette Broyles.

Q. Who is Ms. Broyles?

A. She's Vernadette Broyles.

Q. I know she is, but what is her connection?

A. She's an attorney in Georgia.

Q. Do you know why she contacted you?

A. I was sending e-mails to a friend, Jim Hashem, and he was sharing them with Vernadette Broyles because Jim Hashem's wife is Vernadette Broyles' sister.

Q. Okay. And what does Vernadette Broyles do for a living? What's her --

A. She's an accomplished attorney.

Q. Where?

A. In Georgia.

Q. What kind of accomplishments does she have?

A. I believe she went to Yale undergrad, Harvard Law School. She was -- she worked for Child Protective Services. She worked in the Georgia state adoption systems. And she has done a lot of stuff. I don't

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have her CV, but I know that she's done a lot of different things.

Q. Okay. Tell me about your initial conversation with Vernadette Broyles then.

A. By e-mail or phone?

Q. Phone.

A. Okay.

Q. Verbal communication.

A. Say it again.

Q. Verbal communication.

A. Verbal, okay. We talked by phone the first time. I was in Southern California, and we talked about her interest in talking with me because she was involved in cases where children and adolescents were telling people in the public school system that they were the opposite sex. And she got involved in it because the parents were not doing anything that the school wanted them to do, and they were taking the children away from the parents, and then they were --

Q. "They" being?

A. Child Protective Services.

Q. The governmental agency in Georgia, I take it?

A. Yes. Of which she had worked at since I think the late '90s for like ten years maybe.

Q. She being Vernadette Broyles?

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A. Vernadette Broyles, yes.

And so she was wanting to know if I had any experience with children or adolescents that claimed to be the opposite sex.

Q. Define what you mean "claimed to the opposite sex." I mean, I think I know, but I want you to articulate on the record.

A. The child or the adolescent at some point during therapy or some point during evaluation would say that "I'm a female" or "I'm a male" when they were clearly not.

Q. In other words, the adolescent would say -- would be biologically a male but say "I'm really a female"?

A. Right.

Q. Something like that?

A. Yes.

Q. Okay. Please go ahead.

A. And so I have -- over the years, I have seen those kinds of individuals in a variety of settings. And so she was asking my experience about that and how long and what basically my CV was and whether or not I was this and that. And so that was our conversation.

The initial conversation took place either in very late February of 2019 or early March of 2019, and

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then she said, "My husband is a Tennessee Volunteer fanatic, and we're coming up to the Nashville area to see them play basketball in the tournament." So we met for lunch.

Q. You and Vernadette?

A. Vernadette Broyles and her --

Q. Husband?

A. No, her brother-in-law, Jim Hashem, and my wife.

Q. Who you knew?

A. So we met for lunch, and then we drove back to our house, and then we spoke that afternoon for about three to four hours.

Q. About what?

A. About me coming alongside to work with her to provide her psychiatric expertise around the issue of psychiatric illness, treatment, and my experience with individuals who claim to be the opposite sex.

Q. Is there a term you use for an adolescent who is male but claims to be female? Is there a term that we can agree on?

MR. GANNAN: Objection. Vague.

A. The term that's colloquially used is "transgender." That's the term that I hear tossed around and I see in the media. If I work with somebody

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long enough and I'm able to establish a diagnosis, the diagnosis, if they're really distressed by the fact that they feel that they are the opposite sex, then the diagnosis of gender dysphoria is proffered.

Q. That's the reason I asked the question because I'm familiar with the term "transgender." It's used by a lot people. I'm more interested in a more medically oriented term, and that term would be? Say it again, please, for the record.

A. Gender dysphoria, which is a psychiatric term, not a medical term.

Q. Well, psychiatry is a branch of medicine, is it not?

A. I'm trying to be specific for you.

Q. Sure. I appreciate that. I'll go with what you said. It's a psychiatric term that is recognized within the psychiatric profession. Am I correct?

A. Yes.

Q. And so define for the record "gender dysphoria," just so the record is very clear as to what definition you are ascribing to that two word couplet.

A. This is an individual who, for a minimum time, usually six months, is extremely distressed over the fact that they believe that they are the opposite sex. So if they're a male, they believe they're female. If

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they're female, they believe they're a male.

And they're verbal about it. Some of their behaviors indicate it. The parents are concerned. Siblings are concerned. Peers are concerned, and they tend to vocalize it in a variety of settings: At home, at school, in the community, and especially on social media platforms.

So the diagnosis is offered when you see these symptoms and sometimes signs for probably a minimum of six months.

Q. And when you say "distressed," would you elaborate on what you mean by that term?

A. They are upset. They have episodes of depression. They have episodes of high anxiety. They may be using substances. They may be badgering their parents or peers or friends. They're extremely disturbed by the sense that they're in the wrong body.

Q. And tell me if you would -- I'm going to circle back. You've had a lot of experience with adolescents in the Los Angeles area, as you described earlier. Was that your first introduction to I'll just use the phrase "in the trenches experience with gender dysphoria with adolescents"?

A. No.

Q. When was your first introduction to that?

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A. I was medical director of a juvenile sex offenders program in Nashville, Tennessee, while I was at Vanderbilt School of Medicine, and we averaged about 90 to 100 children and adolescents who had, for whatever reason, been adjudicated and required residential treatment, because they had been involved in sexual activity with someone either older, same age, or younger.

And there were individuals that came in stating that they were in the wrong body, that they were the opposite sex, that they were highly distressed about that, and that's my first encounter with it.

Q. What time period would that be?

A. I was at Vanderbilt from August of '95 until August of 2000, and I believe I was at Hermitage Hall from '97 to 2000.

Q. So over 20 years ago when you first had actual practical experience with gender dysphoria. Is that a good generalization?

A. No. I was also medical director of a facility called Pine Point in Jackson, Tennessee, and we had, I think, two or three individuals. Pine Point had a male side and a female side, and the male side was for juvenile sex offenders, but the female side was not. It was just for adolescents who could not stay in the

community or stay at home. But we had one or two girls that were claiming to be boys, and then we had one or two boys that were claiming to be girls.

Q. What time period are we talking about there?

A. I believe it was from 1993 to 1995.

Q. All right. So was '93, that period of time, the first time you had actual, I'll call it in the trenches experience with adolescents who are --

A. That was the first time as a physician.

Q. Yes.

MR. GANNAN: Make sure you let him finish his question before you answer.

A. Sorry.

BY MR. WILLIAMS:

Q. Well, did you have experience before you became a physician --

A. Well --

Q. -- or not as a physician, I should say.

A. It's unusual. I worked in Detroit at Chryslers on the line for a year.

Q. Before college, during college, after college?

A. Before college. A friend of mine and I were building a 32-foot catamaran in Grand Haven, Michigan, but we discovered that we didn't have any money, so we worked at Chryslers, and we got paid a lot of money,

and there were people there that were -- that looked -- that acted like men but were dressed like women. And I remember several times talking to my peer group and asking, "What's up with those people?" And they said they -- they had a specific word for them, but they were -- they were men claiming to be women, and so they wore skirts. They wore bras. They had their hair all done. They had makeup on, and they worked at Chryslers.

So that's the first time in my life that I'm aware of that I encountered that kind of issue.

Q. What was the term they used?

A. I don't remember the term.

Q. Was it transvestite?

A. No. It was a pejorative term, and I don't remember what it was.

Q. All right. Having had that experience at Chrysler, did that pique an interest in that part of psychiatry when you eventually went to medical school and started focusing on psychiatry?

A. No.

Q. When did your interest in what I'll call gender dysphoria actually start?

MR. GANNAN: Objection. Vague. Assumes facts not in evidence.

A. I had no particular interest in any particular diagnosis. I was interested in psychiatry, and I was interested in child and adolescent psychiatry, and positions were offered, and I took the positions. And in some of the positions, I encountered individuals that were claiming to be the opposite sex.

BY MR. WILLIAMS:

Q. Did that engender in your mind a need to learn more about that from a professional point of view?

A. Every patient that I encountered in my career engendered an interest in knowing more about what they were suffering from.

Q. Okay. Did you take any special coursework or seminars or a more targeted formal or even informal education to learn more about what we're talking about here?

A. Yes.

Q. What did you do?

A. I used the -- when I was at Vanderbilt, I used the Vanderbilt medical library. I also attended conferences in San Diego and Vancouver about individuals, children, adolescents that had been involved in sexual activity. And during some of those conferences, grand rounds, research in the medical school, I would come across individuals who claimed to

be the opposite sex and I would read about them or I would listen to the presentation.

Q. Just for my edification, obviously, you've had decades of experience in this area. Is there a typical age where this gender dysphoria might manifest itself in adolescents?

A. When you use the word "adolescents," I'm not sure what you mean by "adolescents."

Q. Well, let me refine it. Thank you. Because different people define that term differently.

Adolescents for me are typically 12, 13, up until probably late teens, 16, 17, but that may not be a technical term that is correct. I'm just telling you what I use it for.

A. The medical definition of "adolescence" is when puberty starts, that is the beginning of adolescence.

Q. And that can be different for different children; right?

A. In the African American population, it's happening at eight and nine years old.

Q. Is there a typical age that you can point to that you would be looking for?

A. The typical standard age for girls is between 10 and 12 and for boys it's 11 and 13.

Q. So if you use those as benchmark, that would be the chronological beginning of adolescence, would that be correct?
A. With puberty.
Q. Yes. And when does adolescence end typically?
A. Medically adolescence doesn't really end until the very early 20s. We know that the brain matures from the brain stem forward to the frontal lobe, and so technically, medically, adolescence ends in the very early 20s.
Q. So it literally could be a ten-year span?
A. Yes.
Q. And so when you use the term "adolescence" in this deposition, are you talking about the time periods that you've identified for girls and boys through their early 20s?
A. Yes.
Q. Of course, there's a difference between adolescence from a medical psychiatric point of view and minors and adults from a legal point of view. Are you aware of that?
MR. GANNAN: Objection. Vague.
A. Yes.
BY MR. WILLIAMS:
Q. I can't speak for Tennessee, but in Florida,

if you are over the age of 18, you are no longer a minor, you are an adult. I suspect that's probably true around the country.
What's been your experience on that?
A. Where?
Q. Wherever you've practiced.
A. Okay. In California, the legal age can depend on what the patient is seeking. So the standard legal age for treatment of a 16-year-old, they can give consent for psychiatric treatment. A 12-year-old can go into a clinic and have an abortion without parental consent or parental knowledge. So it depends on the specific medical need that determines the age.
Q. In California?
A. In California.
Q. How about Tennessee?
A. Tennessee is 18, and a 16-year-old can consent to psychiatric treatment.
Q. Without parental consent?
A. Yes.
Q. Okay. So I would assume, then, it's state specific. Is that your basic belief?
MR. GANNAN: Objection. Calls for legal conclusion. Speculation.
A. I have only been in two states. I can't

address the other states, but I know that in California 12-year-olds can consent to certain procedures and 16-year-olds can consent to psychiatric treatment and 18-year-olds can consent to as an adult.
BY MR. WILLIAMS:
Q. And in California, is that a matter of state law, statute?
MR. GANNAN: Objection. Calls for legal conclusion.
A. I believe it's state law because I was in two different counties and it was the same age, but that's LA County and Ventura County.
BY MR. WILLIAMS:
Q. Let me be clear. Is it your belief that those differing consent ages that you've described are governed by a state statute statewide?
A. I believe they are.
Q. All right. What's the -- have you ever had experience with a human being who was not an adolescent, using your definition, who experienced gender dysphoria?
A. Yes.
Q. What is the youngest you've dealt with?
A. Chronological age?
Q. Yes.

A. Middle school.
Q. Middle school?
A. I think she was in the 6th grade.
Q. I guess that's state -- middle school in Florida is different than, I guess, it is elsewhere?
A. In California middle school is 6th, 7th, and 8th grade. And in Tennessee middle school is 6th, 7th, and 8th grade, so middle school.
Q. Same in Florida, by the way. All right. So 6th grade is the youngest that you can recall?
A. Yes.
Q. And that's generally about 12 years old. Would you agree?
A. No.
Q. What age is it, in your experience?
A. I've seen 11-year-olds in the 6th grade.
Q. All right. So whether it's 11 or 12, 6th grade is the earliest grade that you can recall having dealt with an adolescent who was experiencing gender dysphoria. Is that an accurate statement?
A. If it's an adolescent, yes. That would be the youngest that I've seen as an adolescent.
Q. Have you seen younger human beings than adolescents that experience gender dysphoria?
A. Yes.

Q. And what is the youngest person you've seen, period, that experienced gender dysphoria?
A. Five.
Q. Really?
A. Yes.
Q. As much out of curiosity as anything, how did you come to see a five-year-old for gender dysphoria?
A. I love this story.
Q. I'm all ears.
A. I only see two. She lost all of her hair. She was a triplet, three girls, identical girls with booming hair. And she lost it all over the course of two or three weeks. And so the parents went to their primary care doctor. They went through all the procedures, and they couldn't discover a cause. I actually sent her to Stanford because I thought maybe, maybe she had this illness or that illness or they could do whatever, because her sisters were booming hair.

And so they brought her to me to work with her so that she could come to understand, accept, explore the fact that she was bald, eyebrows, eyelashes, gone. Alopecia universalis. And she was a wonderful little girl, and we would do play therapy, and I introduced -- there wasn't a Mrs. Potato Head back in the '80s. So I

introduced Mr. Potato Head, and she said one time, because I was working to help her wear a wig. And she looked at me, and she said, "Mr. Potato Head -- you're doing to me what I'm doing to Mr. Potato. You are wanting me to wear a wig like I'm putting eyes on Mr. Potato Head." It was just such a brilliant observation that she made.

And she finally did wear a wig, but she went through this period of about a year and a half where she claimed to be a boy because she had lost all her hair, and so she was greatly distressed. It bothered her for a long period of time, and she talked about it, and she was talking about it in school. But back then they didn't report it, and they didn't do anything about it.

And she finally started wearing the wig, and she actually started to play around with the wig. She would be at a bus stop with her parents and other people would be there, and she'd suddenly go, "Oh, my God, I've lost my hair," and she would hide the wig, and then everybody would see she was bald. So she actually started playing games with it and had fun with it.

So it lasted probably about three years, and then it slowly went away, and she accepted the fact

that she was a girl and that she was bald and she wore a wig.
Q. Was there any nexus between the alopecia --
A. Universalis.
Q. -- universalis and the gender dysphoria from a biological point of view, to your knowledge?
A. No. All her lab works, all her x-rays, all the consults at Stanford, at UC Davis, she was physically fine. They could not find the etiology of her alopecia universalis.
Q. And did she -- did you follow this child for very long?
A. Yeah, for about four years.

In fact, I ended up seeing her mother, her father, and her sibling, because it was -- well, just one sibling -- they were triplets, but I saw the girl that lost her hair and then one of the siblings. It was really devastating to the family. I mean, just her sisters had just booming hair. I mean, it was like -- and she was completely bald. And so the family had -- they were in mourning. It was really sad.
Q. You followed her from what, five to nine, five years old to nine years old?
A. Yeah, from '86 -- '86, most of '86, '87, '88, '89.

Q. And was she suffering or experiencing gender dysphoria when she was nine years old?
A. No. It peaked -- it peaked for about a year and a half, and then it slowly went away over the course of therapy, which was not specific for that. The therapy I was doing was to help her accommodate to the fact that she had lost her hair and her sisters had booming hair. And it wasn't called gender dysphoria at that time.
Q. What was it called?
A. I believe it was gender identity disorder. I think it was DSM-III. I don't think it was DSM-III-R. I'd have to check. But it was an issue, and we would talk about it, and I would point out to her that you're an identical twin. Your sisters are female, and she would argue with me in her little way that she would argue. And sometimes she would get angry, and she'd say, "You don't know what you're talking about. She'd throw the wig at the corner, and she'd walk out of the office." I love this little girl.
Q. I can see why. I can see why.
A. Her parents grew up together, and they married. And then this catastrophic event happened, so I worked with them a long time, individually and as a family, and they were okay, and then they were gone.

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Q. And you don't know what -- how she's matriculated into adulthood, I take it?
A. No. I ended up leaving Sacramento, California, and there was no follow-up, but the therapy had been completed.
MR. WILLIAMS: Let's take a break.
(A brief recess was taken.)
BY MR. WILLIAMS:
Q. We have to go back about 20 minutes or more because I think I asked you a question earlier about how you got involved in this case, and you talked to me about the lawyer in Georgia that you met with with her husband or friends --
A. We had lunch, but then we met at our home.
Q. Right. So follow through to this case. Did that meeting have anything to do with this case that we're here today on?
A. She made several proposals, and she was in the beginning of starting this.
Q. Starting what?
A. Starting this process of defending, I think, parents who have -- are in danger of losing their children because the children are claiming the opposite sex and the school is demanding that something happen, and Child Protective Services is removing the children.

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So she's in the process of taking a -- not a detour, but another branch into law and so --
Q. Well, amplify what you just said, because it's a little perplexing to me, to be honest with you. Parents have a child, and the child is -- let's just say she's an adolescent, as you defined it, in middle school. The middle school child is experiencing gender dysphoria, and it's manifested to others outside of the family, and the school system, I guess, is demanding that the parents do something unless they're going to take the kid away? Is that what you're saying?
MR. GANNAN: Objection. Vague. Assumes facts not in evidence.
A. My understanding is that when -- what she presented -- what's happening was that the adolescent would say something in the public school setting, and the public school setting would let the parents know, and then the public school setting would follow up and want to know if she's getting treated for this. And if the parents said no, the school would contact Child Protective Services.
CPS, Child Protective Services would then contact the family and want to know if their daughter or son is getting treatment, and if the family said no, CPS would come out for a home visit, do an evaluation.

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And if the parents said no, they weren't going to do it, then CPS would take the child and put them in foster care in emergency placement.
So she was getting calls from parents saying that Child Protective Services had taken their son or daughter, and in some instances the parents were not allowed to see their son or daughter, not allowed to give consent, not allowed to be a parent, and so she had gotten -- because I think I had said that she had worked for Child Protective Services in Georgia for a lengthy period of time. So she was very familiar with that operation and how people did things. So she was increasingly concerned that this was happening and was --
Q. "She" being?
A. Vernadette Broyles.
Q. Yes.
A. Vernadette Broyles' husband is an attorney, and apparently they decided that she would branch off into this kind of work exclusively, and so that's apparently what she's doing.
Q. From the conversations that you had with Ms. Broyles, did you garner an understanding as to what the, quote-unquote, treatment would be that the parents were supposed to be providing to the child?

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A. What Vernadette Broyles said to me was that they were giving the children hormones and they were doing surgery.
Q. Who is they?
A. Have to be physicians. She didn't state what physicians or what medical clinic.
Q. If a parent had a child that was going through gender dysphoria and Child Protective Services said, "Are you providing treatment for your child?" that's the kind of treatment that they expected the child to receive, surgery and hormones?
A. That's what Vernadette Broyles presented to me.
Q. If the parents were not providing that form of treatment, then the parents were?
A. Negligent.
Q. Well, they were -- whether negligent or not, they were exposed to having their child taken away from them by Child Protective Services and put into some sort of home; right?
A. Yes.
Q. And if that happened, the child being taken away, would the child then get treatment that the Child Protective Services would mandate or something like that?

A. Yes.
Q. Okay. And this is in Georgia?
A. I believe that the cases she was talking about at the time in March of this year were in Georgia, but I don't know for sure.
Q. Okay. In any event, Ms. Broyles apparently determined that she would focus on this area of the law, and that was part of the discussion that you had with her. So carry before me forward, Doctor, to how we get you into this case as an expert witness. What's the chronology and the connection?
A. What we agreed on is that --
Q. "We" being?
A. Vernadette Broyles and myself, agreed on that I would send her articles, literature, newspaper things about this issue. And so I sent her these articles, and at some point I believe -- I believe it was April we had --
Q. Of 2019?
A. Of 2019. There was a phone call involving myself, Vernadette Broyles, and a person named Roger Gannam.
Q. And is that the same Roger Gannam that is seated to your right?
A. Yes.

Q. Did you know Mr. Gannam before you got the phone call?
A. No.
Q. Tell me about the phone call, please.
A. The phone call was a discussion about -- a discovery discussion, what my expertise was, what kind of doctor, what kind of practice, that kind of stuff. It was a handshake over the phone. And then it was agreed on that there was a -- there was a specific case that was in Florida and that materials would be sent and discussions would ensue, and I became -- I don't know that I can say expert witness, because I think the judge has to decide that, but I became a person who is in medicine and specializes in psychiatry and subspecializes in child and adolescent psychiatry, and have been working with Roger Gannam since, I believe May, late April -- April, yeah.
Q. Well, I think you are an expert witness. The judge just determines whether your testimony will be admitted into evidence or not.
A. Thank you.
Q. I think that would be the proper nomenclature. What did you tell Mr. Gannam in response to this inquiry as to your area of professional expertise?
A. What I have stated previously, that I am a

physician, my specialty is psychiatry, my subspecialty is child and adolescent psychiatry and that I have worked in this discipline for about 40 years and that I have a background that is involved in Tennessee, it's involved in California, it's been academic, it's been in the community, and it's been with juveniles in confinement and that I had worked with the Department of Justice and that I had been medical director of two juvenile sex offender programs. And so that discussion was a look at whether or not I had the expertise required to help them.
Q. And did that expertise required to help them include an expertise in the diagnosis of gender dysphoria?
A. Yes.
Q. And did you discuss gender dysphoria in your talk with Mr. Gannam back in April of this year?
A. I don't think we specifically talked about that. Although, I -- I believe it came up. I don't generally talk about criteria for diagnosis. Most people are looking to see whether or not -- I believe Roger was looking to see whether or not he could avail himself of my expertise, and he was trying to assess whether or not that I had that.
But I do believe that we did talk about gender

dysphoria, but I think the conversation at that time or a later conversation had to do with the ordinance -- not ordinance, that's -- that blows up, right. The law in Tampa.
MR. GANNAN: It is called an ordinance.
BY MR. WILLIAMS:
Q. Well, you hit the nail on the head. It is an ordinance. And it was passed by the City Council here in Tampa over two years ago. And it is the law in Tampa, at least within the city limits.
A. Okay.
Q. So I take it from that conversation with Mr. Gannam he became -- he's not the witness, but is it your perception that he became comfortable with your area of expertise and the breath and depth of your expertise as it relates to what he needed from an expert witness?
A. Yes.
Q. Did Mr. Gannam during that first discussion inform you as to what he wanted you to do as an expert?
A. My memory of the discussion was he's determining, through Vernadette and through talking with me, whether or not I would be helpful for him on a particular case. I believe that he thought that I would be, based on my experience, education, and other

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things, and I believe that at that point the decision was made to start to help him because I believe in a short period of time, maybe that night, I was sent material to review, peruse, and evaluate, and we then began correspondence.

Q. What materials were you sent?

A. I was sent the Tampa ordinance. I was sent a declaration by someone named Lawrence Mayer, I believe. I was sent several things on a particular site so that I could access them and read them.

Q. Who is Lawrence Mayer, do you know?

A. He's a polymath. He's a homo universalis. He's a -- he knows everything.

Q. Good for him.

A. It is good for him. People like that taught me medicine, so that -- I think he is at Harvard. I just know that he's been at all the elite universities. He's been at Stanford -- he's just been -- Michigan.

Q. What is his last name again?

A. Mayer, M-A-Y-E-R, Lawrence. I believe it's Lawrence Mayer.

Q. Is he a doctor --

A. Yes.

Q. Medical doctor?

A. Yes.

Q. What's his specialty, if he has one?

A. It's everything.

Q. He specializes in everything he does. Would you undergo brain surgery with Dr. Mayer, would you?

A. Yes.

When I read what he wrote, I remember talking to Vernadette saying, "I can't do what this guy does. He's in biostatistics. He's a psychiatrist. He's -- the list of things, the accomplishments that he has" -- so...

Q. Well, let me follow up, if I may.

He is currently at Harvard Medical School?

A. I'm not sure. I got overwhelmed because I normally -- my education was seeking out people that I thought knew something that was valuable. I went to UC San Diego because there was someone there that I thought knew something of value. And someone like that, you know, if he said you're wrong, then I'm wrong. I mean, it's just -- I don't know where he is.

Q. Today?

A. Yeah.

Q. When Mr. Gannam contacted you, did you know where Dr. Mayer was?

A. No.

Q. But in any event, Mr. Gannam sent you some

writings by Dr. Mayer to review that night?

A. I believe it's a declaration.

Q. Declaration.

Do you still have that?

A. I don't have it. It's on a site.

Q. What's the site?

A. It's the site that Roger Gannam sent me.

Q. Do you remember the name of that site?

A. I believe it starts with Vazzo.

MR. GANNAN: Can we go off the record.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. All right. So Mr. Gannam gave you access to -- I call it a data room.

A. Yeah.

Q. Okay. Back in the old days, we did that in hard paper, in a room. That is where we put all the data. Today it's all digital.

Mr. Gannam provided you with a way to have access to the -- I'll call it the Vazzo data room where you could access materials remotely from your home in Franklin, Tennessee. Is that a correct statement?

A. Wherever I had the computer, I could access.

Q. That's true. Okay. By computer wherever you are, over the Internet; correct?

A. Correct.

Q. And that's how you accessed the declaration from Dr. Mayer; correct?

A. Yes.

Q. Is that the only document that you accessed that was associated with Dr. Mayer?

A. There were other -- I guess you call them declarations. There was one from Christopher that sat here yesterday. There was one from --

Q. Dr. Rosik?

A. Yeah. To me, he is Chris.

Q. Okay. To me, he's Dr. Rosik, so...

A. And there was one from somebody named Glassgold.

Q. Glassgold?

A. Yeah. That's it.

Q. So you had Rosik, Glassgold --

A. And there was another -- there was this --

Q. All right. We need to do this rather methodically.

A. Oh, I'm sorry.

Q. Dr. Hudson is -- when he said the word "this," he was referring to Exhibit 6 to Dr. Rosik's deposition, which is the American Psychological Association's report, the American Psychological

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Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation.

So that was in the data room, the Vazzo data room?

A. Yes.

Q. Okay. Exhibit 6. What else?

A. And I believe Exhibit 3.

Q. That's -- Exhibit 3 is the declaration of Dr. Rosik, which is Exhibit 3 to his deposition, which is dated May 6th, 2019?

A. And I believe Exhibit 4.

Q. Exhibit 4 is the rebuttal declaration of Dr. Rosik and Exhibit 4 to his deposition. And that is dated July 17th, 2019.

A. And Exhibit 5.

Q. Exhibit 5 to Dr. Rosik's deposition is the ordinance that is the subject matter of this litigation, Tampa City Ordinance No. 2017-47. All of those items that you have identified were in the -- what I call the Vazzo data room?

A. I believe they were, plus my declaration and my rebuttal. And Norman Spack, MD, his declaration and his -- not his declaration -- his rebuttal. His rebuttal to my declaration.

Q. Does that describe the universe of documents

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that were in the Vazzo data room that you've accessed prior to today?

A. I believe so, and I'm uncertain as to whether there was something else in there.

Q. In the data room?

A. Yes.

Q. Give me a guess as to what that might be.

MR. GANNAN: Objection. Calls for speculation.

BY MR. WILLIAMS:

Q. And I'm asking you to speculate because you're uncertain.

A. Yes. And because I'm uncertain, I can't speculate.

Q. You can speculate. The record reflects you are speculating.

A. No. I don't see how I can speculate when I'm uncertain. I don't know what else is there, so I'm unsure if something is in there, but I don't know what it is, and there's a part of me that thinks there was something there, but I don't know what it is.

Q. You have no memory -- if there was, you don't know what it is?

A. Right now, I don't.

Q. Okay.

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A. I mean, if I saw it, bingo, I could tell you right away.

Q. You'll remember at 3:00 clock in the morning. If so, call me. I'll probably be up.

Now, I'm familiar with all of the items that you delineated in my answer to my record because I have those same documents, except for the declaration by Dr. Lawrence Mayer. I haven't been provided with that.

What did that declaration say, do you remember?

A. First of all, it's a CV, which that's a weekend reading right there.

Q. I'm sure.

A. And I didn't get past that, because I ended up calling Vernadette Broyles and saying, "Look, you know, there's him, and then there's me, and I'm not a researcher. I'm a clinician."

And she said, "That's why you are valuable, because you actually work with the people. He is busy going around at different elite universities teaching people how to do what you do."

So I basically just read his CV and marveled. I don't think I read anything else of it.

Q. Well, when you used the term "declaration," that's a term we lawyers use in connection with sworn

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statements by witnesses, whether expert or otherwise, that are submitted into a court record from time to time. You have a declaration. Right?

And so apparently Dr. Mayer had a declaration that was in the Vazzo data room. Are you telling me under oath that you didn't read the substantive part of Dr. Mayer's declaration?

A. I may have read snippets of it, but I was really overwhelmed at his qualification.

Q. I gleaned that from your testimony so far, and that's wonderful. Did you read snippets enough to give me a general overview of what Dr. Mayer was saying in his declaration?

A. I can't say for sure.

Q. How long was it? Do you remember the declaration part? I realize the CV was horrendously long. But how long was the declaration?

A. Not horrendous. It was spectacular.

Q. All right. Spectacular. I meant horrendous in a positive way.

A. I just believe I glanced and I -- I really admired what he had -- what he had accomplished, and so I -- I never actually read it in detail because it seemed like nobody ever brought it up and nobody ever asked me to read it. So I concentrated on the

declaration and the rebuttal.
Q. On your declaration?
A. Yes.
Q. Doctor, whatever level of reading of the substantive portions of Dr. Mayer's declaration, not his CV, which was spectacular, whatever level of review/reading that you did of those substantive portions of his declaration, did anything that you read have any effect on your declaration or your rebuttal declaration in this litigation?
A. No.
Q. And I've gleaned from your testimony so far that whatever you read substantively of his declaration, not his CV, you have no memory of it?
A. No.
Q. Yes or no, you have no memory, or you do have a memory?
A. No, I have no memory of it.
Q. So is it fair for me to conclude that whatever Dr. Mayer said in his declaration is irrelevant to your role in this litigation?
A. Yes.
Q. Do you even remember the subject matter of his declaration?
A. I believe it had to do with the issue that

we're discussing today.
Q. What issue is that, sir?
A. The law that has been passed by Tampa. I believe that the reason he was on there is that he had an opinion that was in congruence with what Roger Gannam was attempting to do.
Q. Congruent meaning basically aligned with what Mr. Gannam was trying to do in this litigation --
A. Yes.
Q. -- his clients are? He is the lawyer. He is just advocating his clients' cause; right?
A. Well, I don't know that he is advocating. He is the attorney.
Q. I'll withdraw the question.
Do you know whether or not Dr. Mayer is a consulting expert with Mr. Gannam in this case?
A. We've never talked about it.
Q. Have you ever talked to Dr. Mayer?
A. No.
Q. Period?
A. No.
Q. Ever?
A. No. I would love to.
Q. I'm sure you would. Probably I would too.
But in any event, during your lifetime, you've

never talked to Dr. Mayer about anything; is that correct?
A. Correct.
Q. And if he has a role in this litigation, is it accurate to state that you don't know what that role is, sitting here today?
A. No.
Q. My statement is correct you don't know; correct?
A. Yes.
Q. And I take you did not read Dr. Mayer's declaration in preparing for this deposition today?
A. No.
Q. Is my statement correct?
A. Yes.
Q. Has Mr. Gannam ever told you what Dr. Mayer's role, if any, is in this litigation?
A. He may have mentioned it in one of our conversations, but it wasn't pointed, and he may have -- he may have sent me an e-mail stating that Dr. Mayer's declaration and CV were in the data sharing.
Q. The Vazzo data room that I call it?
A. Correct.
Q. All right. Have you exhausted your memory of

materials that you accessed and reviewed in the Vazzo data room in connection with preparing your declaration and your rebuttal declaration in this case?
MR. GANNAN: Objection. Misstates testimony or assumes facts not in evidence.
BY MR. WILLIAMS:
Q. Go ahead.
A. When you were saying that I remembered, there is an American Psychological Association statement on some policy statement about what psychologists should do, they should affirm -- there's that -- I think it's 2015. There's also -- there's also the 2009 Endocrine Society statement.
Q. That it's in the data room?
A. Yes.
Q. So those two documents you just recalled were also in the Vazzo data room?
A. Your question, boom, it popped up.
Q. That's why I ask questions.
A. Yeah.
Q. That's how you get information.
Okay. Has that exhausted your memory until I ask you another question that triggers something in your mind?
A. I don't believe -- there's nothing from the

AMA. There's nothing from the American Psychiatric Association. There's nothing from -- I don't -- I think that's it.

Q. All right. Then let me go back to your ongoing communications with Mr. Gannam, and I assume you've just been dealing with Mr. Gannam in connection with this litigation; is that correct?

A. Yes.

Q. Now, Mr. Mihet was here yesterday, but I assume you've been dealing with Mr. Gannam solely?

A. Yes.

Q. What did Mr. Gannam tell you he wanted you to do in connection with being an expert witness in this case. What instructions did he give you?

A. He asked me if I would review the materials in that data sharing Vazzo.

Q. Data room I call it?

A. Data room. And then he asked me if I would state my medical opinion about this issue.

Q. Which issue?

A. The issue of people claiming they're the opposite sex and --

Q. Opposite from their biological sex?

A. Yes. And, in actuality, if you're a male, the opposite sex is not female. Biologically that makes no

sense. There is no such thing as opposite sex. But it's used in the media. It's used in the literature, and it -- there's is no opposite sex. You can't be antimale. You can't be antifemale. But it's words that are being used.

I just want to add that because I'm using that word, but it's -- it's biologically impossible. There is no such thing as an opposite sex. I think it's like people say cats and dogs and somehow they're related, but they're different species. But with humans you have male and female, but they're not opposite sex, but that's how people talk about it.

Q. Sure.

A. So he wanted me to make a declaration based on my experience and training and education with regards to can someone be the opposite sex and do these people need to be affirmed or do they need therapy or do they -- what are their problems. So he sent me an outline -- so there was an -- on the data room, there was an outline that guided me in terms of what I -- it was an outline and it allowed me to put my opinion down in outline form.

Q. Did you follow the outline in preparing your declaration?

A. For the most part, I did. I didn't follow it

completely, but my experience with working with attorneys is that I give them what they desire and then they format it into a legal document that works for them.

Q. Is that what happened here?

A. Yes.

MR. WILLIAMS: Off the record.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. And this outline that Mr. Gannam provided to you through the Vazzo data room is still in the data room, is it?

A. I believe so.

Q. And is your declaration -- let me see here -- dated May 7, 2019. I think you said you provide what they're looking for, the lawyers are looking for, they transmogrify it into their formatting, and then you read it, and if it's okay with you, you sign it? Is that what happened here?

A. Yes, because I was in agreement with what they were saying.

Q. I get that.

A. Because I have -- in the past, I have turned down forensic cases or cases with attorneys because they were asking me to do something that I knew was not

true.

Q. Okay.

A. So what I put down there, I haven't seen it, but I assume that it's my signature because I signed it.

(Exhibit No. 1 was marked for identification.)

BY MR. WILLIAMS:

Q. I've had the court reporter mark as Exhibit 1 the "Declaration of Bernard O. Hudson MD." It is dated May 7th, 2019. If you look at page 10, Doctor, is that your electronic signature?

A. Yes.

Q. And did you actually affix your original signature to the original document of this ilk?

A. Yes.

Q. And you provided this to Mr. Gannam who in turn provided it to me?

A. Via certified mail.

Q. Terrific. Okay.

All right. So going back to my series of questions. You signed this document and provided it to Mr. Gannam for his use in this litigation because your declaration as formatted by Mr. Gannam was consistent with the outline that he sent to you and was consistent with what you believe to be your true opinions

regarding the subject matter set forth in your declaration. Is that a fair statement?

MR. GANNAN: You can answer.

A. Yes.

BY MR. WILLIAMS:

Q. I will confess, Doctor, that I was interested in your statements under roman numeral III, capital A, little i., Nos. 11 and 12. And 12 on page 4, you talk about the scientific method. Do you not? Take a moment to read it to yourself?

A. I know what it says, and I'm right here.

Q. Okay. So paragraph 12 talks in part about the scientific method, does it not?

A. Yes.

Q. Define the "scientific method" as you understand it.

A. "The scientific method consists of an instrumental injunction, an accepted apprehension, and a common verity."

Q. Translate that for us.

A. Instrumental injunction is you ask the question, "How does this happen?" You form a way to discover how it happens, and then you share it with other people and see if they see it and understand it the same way. And I'll give you an example.

There are two elderly women standing in this room, looking out at night, and one of them says, "What a beautiful moon." The other one says, "Yes, they're both beautiful."

Well, wait a minute, there's only one moon. So the question is, how is this person seeing two moons? So other people come along and say there's only one moon. So that's the instrumental injunction.

But you have to know how to see something. And you have to know that what you're using to see something is precise. And then you have to know that other people using the same method that you used can see the same thing or understand the same thing.

So the woman looks up and sees two moons. Other people say, "There's only one moon." You check their vision, and you find that the other people's vision is correct and they're able to focus and their retina is fine and the optic nerve is fine and the optic chiasm is fine and the visual center in the brain is fine.

So the apprehension of the part of the universe that you are looking at is correct. But this woman sees two moons. So then you have to evaluate the common verity. You have to evaluate how she's apprehending two moons. And she's apprehending two

moons because she has a distortion in her lens, so she sees two moons.

So if you are using a microscope to look at a cell, you have to make sure the microscope works and that you are focusing on the correct cell.

So the scientific method looks at something, asks a question, determines a way to apprehend and understand what it is and then shares it, a common verity, with other people to see if they can reproduce that in the same way that you reproduce it. That is the essentials of a scientific method.

Q. Is the scientific that you just described and confined, is that universal throughout science?

A. It's the scientific method.

Q. Is your answer "yes"?

A. Yes.

MR. WILLIAMS: I have to make a quick phone call at 11:00. So can we take a five-minute break.

(A brief recess was taken.)

BY MR. WILLIAMS:

Q. Doctor, your discussion of the scientific method in your declaration and just on the record in your testimony today triggered something in me, and was pretty sure I had this book here, and I do. The name of the book is Scientific Method in Practice. And let

me read to you what the author --

MR. GANNAM: Will you state for the record who the author is.

MR. WILLIAMS: Yeah, I'm going to.

MR. GANNAN: Okay.

BY MR. WILLIAMS:

Q. Are you --

A. Gauch.

Q. Huh?

A. I'm sorry. Gauch.

Q. Gauch. Are you familiar with Gauch?

A. Yes.

Q. Hugh G. Gauch, Jr., at Cornell University. At least that's where he was when he wrote this. I have other books on the scientific method, but they're at home, unfortunately. Here is what he says. He describes the elementary scientific method as follows in bullet points:

One, hypothesis formulation.

Two, hypothesis testing.

Three, deductive and inductive logic.

Four, controlled experiments; replication and repeatability.

Five, interactions between data and theory.

And then limits to science's domain.

Is that consistent with your review of the scientific method?

A. No. He makes a mistake, he leaves out the first thing that you do in a scientific method. You have to have an observation.

Q. Is that not implicit in the hypothesis formulation?

A. Science is not implicit; it's explicit. And therefore you have to make an observation in order to form a hypothesis.

Q. All right. From your comment earlier, you seem to be familiar with Gauch, the author of this book.

A. I read a lot over the years. And names pop up.

Q. So you are familiar with him somewhat?

A. I have a mental telephone book of names, and I think he is in the G section.

Q. All right. So can we agree that you agree with all of the items that I delineated from this book starting with "hypothesis formulation," you agree with all that with one exception, and that is the observation component that he doesn't include specifically expressly here, which you believe is the first part, first element?

A. No.

Q. All right. Then tell me what you think of what I just read into the record.

A. What you read is what he wrote.

Q. Correct.

A. What I wrote are the principles of the scientific method. What he is describing to you, lacking the observation part, he is describing to you the instrumental components of the scientific method, how you actually go about it. I provided you the principles of the scientific method.

Q. What is the difference? Distinguish between how you go about it and the principles.

A. The idea and then the action. He is describing the action. I'm giving you the principle ideas of the scientific method.

Q. Do you agree with the action elements that he delineated in this book?

A. I would have to hear them again.

Q. I'll read them to you. Again, this is on page 11 of Scientific Method in Practice by Hugh G. Gauch, G-A-U-C-H, Jr.

Elementary Scientific Method.

One, hypothesis formulation.

Two, hypothesis testing.

Three, deductive and inductive logic.

Four, controlled experiments; replication and repeatability.

Five, interaction between data and theory.

Last, limits to science's domain.

Those are the elements that he delineates. Do you agree with those?

A. I agree with those. Although, without observation, you can't do any of those.

Q. So you would add observation at the top of the list?

A. You have to add observation.

Q. I understand that your opinion is you have to, but you would?

A. My opinion is based on science.

Q. But you would add observation to the top of the list?

A. That's why I put it in the declaration.

Q. And you don't believe that observation is integrally incorporated into the concept of hypothesis formulation?

A. I didn't hear the word "observe."

Q. You did not because it's not there. I'm suggesting to you that maybe it's implicit or imbedded into the concept of hypothesis formulation, but you

don't agree with that, I take it?

MR. GANNAN: Objection. Asked and answered.

A. I think if you're going to write something like that, I think you need to make things very clear. And throughout my career, I've studied science and I've understood the scientific method, and you cannot have a scientific method unless you have a way to observe what you're trying to hypothesize and what you're trying to test and what you're trying to share.

BY MR. WILLIAMS:

Q. All right. Thank you. Let's move on to another subject.

In reviewing your declaration and, frankly, your rebuttal declaration, it occurred to me that -- at least I concluded that, in your opinion, a person's sex is really relevant to every medical diagnosis and treatment. Is that an accurate statement?

A. Yes.

Q. Why is that?

A. Males and females have different genes. They have different DNA, different chromosomes. Their somatic cells are different. Their physiology is different. The way they metabolize medications are different. Your treatment is different based on the size of a person. Males tend to be larger; females

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tend to be smaller.
You have to know the sex. You cannot give someone a physical exam if they don't have breasts, if they don't have male genitalia or female. You have to know the sex in order to know how to do the physical exam, in order to know what questions to ask, in order to know what diagnosis to give, and in order to know what treatment to provide.
Q. So in one sense, if I heard you correctly, your understanding of medical science is that it's in many ways bottomed on the division between men and women, the sex of the patient?
MR. GANNAN: Objection. Vague. Misstates testimony.
A. There are illnesses --
BY MR. WILLIAMS:
Q. Is my statement correct? Can you agree with it or not?
A. Say it again.
MR. WILLIAMS: Read it back, please.
BY MR. WILLIAMS:
Q. Just tell me if you agree with it. If you don't agree, just tell me why.
MR. WILLIAMS: Read my question, please.
(The question was read back as follows:

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So in one sense, if I heard you correctly, your understanding of medical science is that it's in many ways bottomed on the division between men and women, the sex of the patient.)
A. I don't agree with the way you phrased the statement.
BY MR. WILLIAMS:
Q. How would you rephrase it so that you could agree with it?
A. The basis of any medical presentation is the age and the sex. This is an 18-year-old white male. This a 27-year-old white female. You have to know the sex because illnesses are different between the sexes, treatment is different between the sexes.
Q. Okay. And when you refer to treatment, you, of course, are talking about treatment of a disease, I take it?
A. An illness.
Q. Is a disease and an illness synonymous, basically?
A. "Disease" can refer to communicable diseases. It can convey neurologic. So when I use "illness," that's an umbrella term that provides another medical provider the information necessary to know that this is a bona fide illness.

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Q. And disease would be a subset of illness, I guess, if I understood you?
A. I think it's a colloquial term that laypeople use.
Q. Illness?
A. No disease.
Q. Okay. The reason I'm asking is paragraph 13 of your declaration, you say, quote -- and you've got it in front of you there -- "Any abnormal change in the causal biological development of a male or female human being is considered a state of disease." You didn't say "state of illness," that's why I'm asking the question.
A. I tried to be specific there because it's technically not an illness. When doctors talk with each other and they use the word "illness," you think of acuity, you think of the here and now. Development that goes awry from the way it's supposed to is a state of disease.
Q. Development meaning what, sir?
A. Well, this would be -- the way I'm using it is that any abnormal change in the causal biological development of a male or female human being is considered a state of disease, because any development that moves away from male or moves away from female is

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a state of disease, because there is just males and females, there is no other.
Q. Well, would you consider that disease to be a mental disease or a physiological disease or a biological disease? How would you further amplify what kind of disease you are talking about?
A. Impairments in development can affect any organ -- any organ system. It can affect neurologic systems. It can affect cardiovascular systems. It can affect muscular systems, joint systems. So any impairment of that development results in a state of disease. And when the infant becomes a baby, after it's born, it may become an illness, because they may not be able to breathe, their heart may not work right, et cetera, et cetera.
Q. Is gender dysphoria a mental disease or mental illness?
A. Yes.
Q. So amplify for me, if you would, Doctor, what you mean by the word "abnormal" in the last sentence of paragraph 13.
A. In normal embryologic development, you end up with a male or you end up with a female. If there is any change in that, then it's abnormal.
Q. So gender dysphoria is an abnormal change in

the causal biological development of either male or female; is that correct?
MR. GANNAN: Objection. Vague. Misstates testimony.
BY MR. WILLIAMS:
Q. That's not correct?
A. No.
Q. What's incorrect about it?
A. "Gender" refers to masculine and feminine or qualities of either. Biological sex is determined by the sex chromosomes. So when I refer to the development of a homosapien, the development, if it's normal, develops into a male or female.
Gender dysphoria, those people are already developed into a male or female.
Q. And let me correlate that to causal biological development. I'm trying to understand and correlate, to use that term, gender dysphoria with causal biological development. Maybe I'm just mistaken.
Do you correlate gender dysphoria with causal biological development?
A. No.
Q. And so, therefore, gender dysphoria is just unrelated to causal biological development whether normal or abnormal. Is that a correct statement?

A. Biological development is different from phenomenological or experiential development, which is the mind.
Q. And so experiential -- "causal experiential development," would that be a term you would use?
A. No.
Q. Is gender dysphoria the product of experiential development?
A. It is considered a psychological psychiatric illness, which is an illness of the mind.
Q. Not an illness of the body?
A. The mind is part of the body.
Q. Okay. I get that. I'm trying to distinguish between causal biological development -- what do you mean by that, then? Does that include the mind?
A. I'm determining how to educate you without you going to medical school.
Q. Thank you.
A. The essence of biology is structure and function. Go anywhere and say that and anybody that has studied medicine will understand what you mean. Structure, function. Change the structure, you change the function. Change the function, you sometimes can change the structure.
Biological development is causal. It takes

place. The mother doesn't have to say grow an extra leg, grow 12 toes on this foot. It's causal. It's out of the realm of the mind. But in the body, currently, we believe that the only organ that has a structure and a function and has another function is the brain. The brain has a structure, and it has a function, physiologic, biologic, but it also has a function that's the mind.
And the mind is not causal. The mind is whatever your mind is at the time. But your biology remains the same. You breathe. You eat. You move. Your heart beats. Your diaphragm allows you to breathe. Those are causal relationships.
You cannot live without eating. You cannot live without healing. You cannot live without oxygen. Those are causal relationships. They have nothing to do with what you wish. Okay. You can wish you have -- you can run like Gale Sayers, but you don't run like Gale Sayers.
So the mind can come up with all kinds of things that are not causal at all. They're experiential, phenomenological, and so gender dysphoria is a psychological psychiatric disorder.
Q. So you are in your testimony, if I understand it, without having to go to medical school,

experiential and phenomenological phenomenon, I guess, is separate and apart from biological?
A. I gives rise to that. Dead people don't have a mind, as far as we know. But we test, and we don't discover a mind. So we know that causal relationships in the brain can cause people to lose their memory, cause people not to be able to speak well, cause people not to be able to listen to words well.
We know that the structure of the brain gives rise to the mind, and interference with that structure will interfere with the mind. So it develops, and then something changes develop or interferes with develop or changes develop, and then that will change the structure, and that will change the function.
Q. Correlate that back to gender dysphoria --
MR. GANNAN: Objection. Vague.
MR. WILLIAMS: I haven't finished my question yet.
MR. GANNAN: Sorry. Withdrawn.
MR. WILLIAMS: Give me a second.
(A discussion was held off the record.)
BY MR. WILLIAMS:
Q. Can I state accurately that gender dysphoria is the product of experiential or phenomenological aspects, dynamics, whatever you want to call it, not

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biological -- biological development?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. You can answer.
A. I didn't know what he said.
MR. GANNAN: I objected on vagueness. You can answer the question.
THE WITNESS: Okay.
A. The current state of the science is that it is a psychiatric disorder that involves the mind. But there are psychiatric disorders that also involve the mind and the brain. There is no known evidence to suggest that people with gender dysphoria have any causal biological problems with their brain. Although --
BY MR. WILLIAMS:
Q. Brain the organ?
A. Brain the organ.
Q. Go ahead.
A. There is no specific medical tests in terms of laboratories, physical exam, x-ray, CT, MRI, functional MRI, PET scan that will allow you to diagnose a medical condition causing gender dysphoria. It is a product of the mind.
Now, there are cases in the literature that

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suggest that individuals with autism have higher rates of gender dysphoria, but there, it's not clear. So if you think of the structure developing normally, the mind can have all kinds of problems.
The mind can be depressed but not depressed to the point that it affects the brain, but there are depressions that affect the mind and affect the brain. In fact, severe depression, melancholic depression will affect the growth of your skin, affect the growth of your hair, affect the heart rate. So we know that depression can go down deep into the biological causal relationships that exist in the body.
Gender dysphoria there is no evidence in the scientific literature to suggest that it is a biological causal etiology.
Q. You distinguished, I think, between mind and brain, have you not, in your testimony?
A. The structure of the brain gives rise to physiologic control of the body and gives rise to the mind.
Q. Well, go with me, if you would. The brain is an organ of the human body, is it not?
A. Yes.
Q. And the brain as an organ allows the human being to think, have emotions; correct?

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A. Yes.
Q. And so when you use the term "mind," I'm telling you what I think so I can understand, without going to medical school. I correlate that to thinking emotions, stuff like that, not biological phenomenon. Is my thinking reasonably accurate?
A. I lost track. I -- can you repeat?
Q. It's a statement I'm asking if you agree with it.
A. I want to hear it again.
Q. Sure.
A. Because Something happened and I lost track. Am I allowed to ask her?
Q. Sure.
MR. WILLIAMS: Off the record.
(A discussion was held off the record.)
(The question was read back as follows:
And so when you use the term "mind," I'm telling you what I think so I can understand, without going to medical school. I correlate that to thinking emotions, stuff like that, not biological phenomenon. Is my thinking reasonably accurate.)
A. Yes.
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BY MR. WILLIAMS:
Q. In any event, going back to that dichotomy, brain versus mind -- not versus but brain here, mind there, gender dysphoria is more related to the mind; correct?
A. Yes.
Q. The way I've characterized it; correct?
A. Yes.
Q. I'm going to confess to you, doctor, when I read 14, I read it several times, paragraph 14. And I'm not sure I understand it, as I sit here today. Would you please translate for me and for the court or anybody else who reads this deposition in plain English, simple terms, what you are intending to communicate in paragraph 14 of your declaration.
A. The only living human species on this planet are homosapiens. Homosapiens consist of males and females. In a female, the somatic cells, the cells that are not involved in reproduction have two sex chromosomes, and they look like an X under a microscope. And that's why they're called X.
In a male, the sex chromosomes have an X, but they also have a chromosome that looks like a Y.
In a male who has an X chromosome and a Y chromosome, all the information necessary to develop

that human being is available on the X chromosome. The Y chromosome decides genetically whether it will be a male and also hairy ears.

Q. Also what?

A. Hairy ears. I didn't design it.

Q. It happens.

A. In a female, there's two Xs. And it was discovered by Winston Barr in 1946 that one of the Xs shuts down. There seems to be a redundancy of information. You don't need two Xs, so it shuts down. That's the Lyon hypothesis that that Barr body will stay a Barr body forever, and in consequence, the cell only needs one X. So in males you can't have a Barr body if you have an X and a Y, because, if you shut down the X, the cell can't live.

In a female, one the Xs shuts down, becomes a littler dark spot on the edge of the nucleus, called a Barr body. He was a Canadian physician. He discovered it in 1950 -- 1946, and then Lyon, a physician, proposed that this Barr body shuts down and never opens up again because you have all the information you need on the X chromosome.

So in someone who is born "normally," you have a male or you have a female. And in a male, you have an X chromosome, you have a Y chromosome. You have no

Barr bodies because, if you shut down the X, the cell will die.

In a female, you have an XX, and it's thought under the Lyon hypothesis that one of the Xs shuts down because you have a redundancy of information. What that means in practical terms is that in all women, including the women in this room now, when one X shuts down, it changes things. So women, their sweat pattern on their skin is different; whereas in men, it's uniform, because the men can't shut down the X, but because each X may have recessive genes or they may have predominant genes, one of the Xs shuts down. That's why cats with different hair color are almost always female.

So what I'm saying in this sentence is that a natal male, meaning a natural male, has an X and Y chromosome in their somatic cells. A natal female has an XX in their -- a natal female has an X and X in their somatic cells. One of the Xs shuts down in the nucleus, so you end up with one X, and that X is enough to give a woman life. But because there are genes that are active or recessive or whatever, they may have different sweat glands, they may have different nerve distribution. That's the ultimate diversity. It allows, through evolution, females to provide a

different approach to common things that males cannot do, because they only have one X chromosome.

So I go on to say that in men with Klinefelter syndrome, they have two Xs and one Y. What you find in someone with Klinefelter's, when you do a karyotype, when you look at the chromosomes, what you see, when you look at the cell, you see a Barr body in a male. Now, that shouldn't happen in a male, but they have Klinefelter's. They have two Xs. So one of the Xs shuts down and becomes a Barr body in the nucleus. So you end up with XY, which is a normal male, but because the different cells shut down different Xs, you end up with problems associated with Klinefelter's diagnosis.

Q. Which is what?

A. It's a -- Klinefelter's, they're very tall, their arms sometimes will reach above their knees. They tend to have elastic joints. They tend to die on the toilet because, when they push to have a bowel movement, it collapses the valves in the heart. So the cartilage is very -- it's too elastic for the body to withstand the rigors.

Nobody with Klinefelter's can play professional sports like hockey, basketball, football, because they'll damage themselves because the cartilage isn't strong enough to hold the joints together, and

the bones are elongated because those cells are giving different information and causing a different phenotype, a different expression of the genes.

So in Klinefelter's you have two Xs. One X shuts down. You end with XY, which is a normal male, but they're not normal because they have physical signs and they have symptoms, and you can make the diagnosis based on that.

So in a Klinefelter's patient, there is one Barr body. There shouldn't be a Barr body because it's not a female, but because they have an extra X, they have a Barr body.

In a female --

Q. You are talking about a male that has a Barr body?

A. Yes. Because they have two Xs. In a normal male, they just have one X. So in a female with an XXX karyotype, trisomy X, there are two Barr bodies because there are an extra two X chromosomes, and so it shuts it down in the nucleus.

In females with Turner syndrome with a chromosomal karyotype of XO, they don't even have a Y chromosome. They don't even have an extra X chromosome. You can't have the X chromosome shut down. The cell would die. So they don't have a Barr body.

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As an inactivation the only X chromosome would render the cell without DNA.

And although I don't mention it in this paper, I'll mention it to you, because you seem interested. In every cell of the body and every nucleus of the body, there are between 5 and 10 million biochemical reactions per second. That's why, when you have children and you're gone from seeing your children, like maybe a week or two weeks, you have a sense that they're somehow different. And they are different, because we're constantly changing, we're constantly aging, we're constantly moving through time biologically.

So Number 14, I'm trying to explain that there's male and female, but in development, sometimes you have a male that has an extra chromosome and they have a disease or an illness called Klinefelter's, and they end up having a Barr body where they shouldn't have a Barr body.

And in females with trisomy X, where they have three Xs instead of two, they have two Barr bodies. And in Turner syndrome, where they have XO, they don't have another chromosome. They can't shut down the X chromosome. The cell would die.

So that is my explanation for Number 14.

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Q. Have you ever heard of the term or phrase or whatever called "intersex condition"?

A. Uh-huh.

Q. What is that? What intersex condition?

A. It's where they -- ambiguous genitalia, or they have a combination of both genitalia.

Q. At birth?

A. Yes, at ultrasound.

Q. At what?

A. At ultrasound.

Q. Do you know what causes that phenomenon?

A. No.

Q. Are you an expert at all in that phenomenon?

A. No.

Q. Does that phenomenon have any correlation to gender dysphoria, in your opinion, or do you know either way?

A. I'll think out loud. Intersex is a genetic developmental disorder.

Q. Biological?

A. Biological causative, something -- something's gone wrong, and it doesn't develop right, and it develops both instead of --

Q. Either/or?

A. -- yeah. I'm aware of no correlation between

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that and gender dysphoria.

Q. And in any event, that is not part of your expertise as a psychiatrist?

A. If I was to do a physical exam on somebody, which would -- it's usually identified at birth, so if they got to me and no one has done a physical exam, I would have to say, "What's going on?"

Q. Sure. Okay. Turn to page 5. And you have a topic, little roman iv, "Evidence-Based Practice Therapies," and you talk, at some length in the next few paragraphs, about that subject. I don't want to go through all of your declaration on that, because it would take a long time.

But my question to you is: What is the relevance of this subtopic to your expert opinions? Can you summarize it for me?

A. I would like to read it briefly.

Q. Sure. Absolutely.

MR. WILLIAMS: Actually, if you want to take an early lunch break, Roger, give you some time to review it carefully. That would be okay with me, if that's what you would like to do.

MR. GANNAN: Okay.

(A discussion was held off the record.)

MR. GANNAN: I think we'll be fine, but

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Dr. Hudson has a 6:15 flight.

MR. WILLIAMS: Oh, trust me. We won't have a problem.

(A luncheon recess was taken.)

BY MR. WILLIAMS:

Q. Doctor, when we broke for lunch you were going to take some time to read paragraphs 20 through 22 of your declaration, pages 5 and 6. Have you had an opportunity to do that?

A. Yes.

Q. What is the significance of including your discussion in paragraphs 20 through 22 about evidence-based practice therapies? Why did you include that?

A. I included it because therapy is important for individuals who suffer from psychological or psychiatric illness. And I included it because I wanted to show that there are therapies that are available for parents, for children, adolescents, for families, and there's different kinds of therapies, and many of the therapies that are recommended by the American Psychological Association, the American Psychiatric Association are evidence-based therapies. They are shown that, if you do the therapy in the way that its proscribed, that you'll get better results.

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Q. Prescribed.
A. I'll go with that.
Q. "Proscribed" is a totally different word.
A. I was uncertain as to what to say. And I also did it because there is no evidence-based practice therapy for people that "transgender." So there are evidence based therapies that are available to use with people who have gender dysphoria, but the ban, like in California and in other places, says you have to affirm.

And what's happened in my experience is that it's caused two things to happen. It's caused patients to fear going to therapy. It's caused therapists, whether they're LCSWs or marriage and family counseling or psychiatrists, running afoul of the law if they don't do this affirming.

Q. Go ahead, please.
A. I wanted to demonstrate that there are therapies available for people who have gender dysphoria if they have comorbidities; if they have anxiety disorders, which many people with gender dysphoria have; if they have depressive symptoms, which many people with gender dysphoria have; if they have substance abuse issues, which many gender dysphoric people have; if they have histories of physical and/or

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sexual abuse, which many of these individuals have; if they have experiences where they've been bullied or accosted or assaulted in some way, which many of these people have.

And so I wanted to demonstrate that there are therapies available for these people if they have these comorbidities. But there is no therapy specifically for gender dysphoria. What you do is you treat the outlying symptoms, and then you work with the patient to the develop a therapeutic approach that aids them in assisting how to see themselves, how to deal with the "stigma" that's attached with that.

So those three sections it's -- Number 20 is an introduction into their various kinds of therapy. Number 21 is working with the patient so that you can lessen their symptoms, and then 22 is pointing out that there is no -- in the literature, a therapy for gender dysphoria. But if they have other symptoms, you can use the evidence-based therapies with them.

Q. You've used the word "therapy" quite a bit in your answer and also in your declaration. Give me a working definition of the word "therapy" as you understand it in connection with your testimony?
A. It's the restoration of the self. People -- the self is what, when you're asleep and you are

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dreaming, somebody is watching, and it's you. And that's the self. And what people come in for therapy for is difficulties with the self, difficulties in relationships, difficulties with their own relationships with themselves.

And so therapy is really restoring the person to a civil relationship with themselves, and there's various ways to approach a patient. There's various therapies that are evidence-based to use that with patients, and some of the guidelines that claim to be standards of care or evidence-based prevent you from doing that. And it's heartbreaking that you can't help some of these people.

Like in California, I had to say to them, "The law says I'm not allowed to do this."

Q. What are you not allowed to do in California?
A. You are supposed to affirm, and you are not allowed to say that someone is not the opposite sex.
Q. When you say "affirm," what does that mean? Be specific.
A. You're supposed to -- when somebody comes in and claims that they're a "transgender," you are supposed to say, "Yes, you are." And then the guidelines say you are supposed to educate them, you are supposed to let them know about the stigma attached

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to this, and that they'll be -- people will be aggressive, they won't accept you, they won't tolerate you. That's not therapy. That's -- that's instruction. That's an instructional manual.

Therapy has to do with them bringing into the session the problems they have and then you helping them deal with those problems. And one of the best signs that therapy is over is the patient says to you, "You know, if I wasn't coming here, I wouldn't have any problems. You're the problem now."

Well, that means that they brought the problems into the therapy; they've restored themselves to themselves; and they don't, any longer, need to see you because they're doing well on the outside. They're no longer dysfunctional.

Q. Doing well on the outside by themselves?
A. In terms of activities of daily living, in terms of work, in terms of relationships with friends or family, in terms of living in the real world. One of the goals is -- in therapy, is to help people deal with the fact that this world, that these people around are not always going to get along.

And a lot of people come in -- everybody comes in to therapy and says the same thing, basically: "I have a problem with that person. I have a problem with

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that person, and it's their fault, and it's their fault." It's not. That's the way the world is.

And so therapy really is helping someone deal with fact that the world doesn't negotiate, the world doesn't really care what you feel and how you think. And you have to live in the world in a civil way. And if you have a psychiatric illness that's interfering with that, then that's what therapy attempts to address. If they're really psychiatrically ill, you may have to use psychopharmacology to help them.

So my experience in California was that you had to affirm, you had to educate, you had to go through this long list of things that you had to do. That's not therapy. What that is, it's just telling the person what they already know.

Q. Informational?

A. Yeah. They already know that the world doesn't accept them. They already know that they can be bullied. When I was at Vanderbilt, I had several people that were homosexual, and one guy came in one day, and he had a huge black eye. He had a big cut on his jaw. He was downtown Nashville, and somebody thought he was gay, and he was, and he got assaulted.

And he says, "I'm just not going to go downtown anymore."

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Well, you know, if you don't go downtown, you know, you don't go out with friends, you don't do things. And the goal is for them to live in society. But society sometimes doesn't do what we want it to do. And he suffered greatly for it, and it took a while for him to finally go back downtown, but he went downtown with friends. He didn't go alone anymore. So we worked on does he have a friend? Can he do downtown with that friend? Can he have a good time with that friend? Will he feel protected with that friend?

So almost everyone that I've spoken to over the years has no problem working with people that have sexual instinct, sexual desire, sexual identities. They don't have a problem with that. That's fine. Live your life. Do what you want. If you have this illness, I'll help you with it and we'll plan some therapy.

But these bans prevent you from doing that. They cut you off before you're -- before you can do an evaluation, before you can process what the person is like. Many people take a long time to open up. I've had people sometimes in therapy one to two months before they finally are able to uncover what really is bothering them, and I've had people that are -- have been living their lives based on something that

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happened when they were a teenager or when they were a child, and they are still doing the same thing. It's a repetition-compulsion kind of lifestyle.

And by sharing the observations that you seem to do this when this happens, you seem to say this when this happens, you share the observation. And then they begin to incorporate that observation, and you begin to see them change. And you begin to see what many people call an observing ego. They're able to observe themselves and say, "Okay. I'm feeling this way, and the reason I'm feeling this way is not because of the person. It's because I feel this way." And they're able to order their life. They're able to -- they have a direction.

Many people, as an example, come into therapy with an old map, and they're trying to navigate streets that longer exist or the streets are bigger or there's building in the way. And what you do is you update their map. You help them do that because it's unconscious many times. They don't know that they're actually doing it.

You know, the famous thing about alcoholics is they're in denial. Well, denial is unconscious. They don't know they're in denial. You have to help them access that. You have to help them dig it up so they

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can see that they're in denial.

Many times with individuals that, say, have a substance abuse problem, let's say alcohol, they'll say, "Well, I only drink six beers," and I'll say, "Why not nine? Why not ten? Why do you stop at six? What is so magical about six? Tell me about six. What does that mean?"

And, oftentimes, you can find out information because the six is a screen memory for other things that took place in their life. They've put everything into the six beers.

I had a woman that was absolutely petrified by spiders, and it took a while, it took a long while for her to finally realize that on the day she was raped, she was in a barn and she was looking up at a spider in a spider web. So she took the assault and the trauma, and she projected it onto a spider.

That takes time. And that takes evidence-based therapy so that you can help them access that, because it's highly defended. It's a wall that goes very high and goes very deep and goes very wide, and you have to help them remove brick by brick by brick so that they can see that the trauma still exists, but it's been projected onto a spider or it's been projected onto a man or it's been projected onto a

female.
So the steps there, 20, 21, and 22 is to point out that there are available evidence-based therapies, and there's a variety of evidence-based therapies based on the scientific method and that there is no specific evidence-based therapy for people that are claiming they're transgender, but you can still help them by alleviating their comorbid psychiatric problems, such as depression, anxiety, panic attacks, sometimes agoraphobia. You can help them with substance abuse problems. You can help them. But the ban cuts you off.
Q. Well, I realize that you don't live in the city of Tampa, you don't practice psychiatry in the city of Tampa. You don't even live in Florida. So your experience with the ban, as you've talked about, is primarily California's, is it not?
A. It's California, and it's the reading of the Tampa ordinance.
Q. All right. Let's stay with California because that's where you practiced. You haven't practiced in Tampa, have you?
A. No.
Q. So going back to California, it's a statewide statute. I think we established that earlier that, to

the best of your knowledge, that bans -- that is the ban. I don't have a copy of that statute, but what you told me earlier, Doctor, is that if a client comes in, all you can do is provide them with information or instruction. You can't provide them with therapy. Did I -- was that an accurate statement?
A. You have to affirm, and then you have to instruct.
Q. "Affirm" meaning you are what you are?
A. Yeah.
Q. I want to make sure that term is clear on the record. So define "affirm" as you use it in the context that we've been discussing. "You have to affirm," what does that mean?
A. If somebody comes in and claims they're the opposite sex, you have to agree with that. You have to affirm that they are the opposite sex.
Q. A female human being comes in and says, "I'm a male human being." You, the psychiatrists, have to say, "Yes, you are the male human being." Is that what you are saying?
MR. GANNAN: Objection. Vague.
You can answer.
A. Yes.
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BY MR. WILLIAMS:
Q. You don't question what they've told you. You just affirm it -- confirm it, almost, is really what you are saying?
MR. GANNAN: Objection. Vague. Misstates testimony.
A. There are instances where the law interferes with treatment, and I have tried in my career to abide by the law. But I will say to people, "Given the fact that there's a law that does not allow me to question you in that area, are there other things that you are suffering from that I can help you with?"
BY MR. WILLIAMS:
Q. All right. Well, if the law wasn't as it is in California and somebody came in to say -- who was female and says, "I'm a man," what would you do differently? What therapy would you provide to them potentially?
A. Well, as I mentioned there is no evidence-based therapy for people who claim that. So you look for any kind of comorbidity, and you then use evidence-based therapy to treat that comorbidity.
Q. "Comorbidity," define that, if you would.
A. They come in and you diagnose gender dysphoria. Many of these individuals not only have

gender dysphoria, they have depression, they have anxiety, they have substance abuse problems, they have self harm, they have suicidal thoughts, they have maybe attempted suicide. So you help them in those areas.
The goal is you may not be able to get to the bull's-eye, but you can certainly circle around and eliminate or attenuate the other symptoms that they're suffering from. You do help them. You help them from the outside towards the in. And then if you are able -- and I have been able to do this with people that are claiming that they are the opposite sex, we go through the science of biological sex. We go through how that can take place, and more often than not people end up saying, "No, I guess I'm not the opposite sex."
I have had --
Q. They reach that conclusion on their own?
A. With help through the therapeutic process, through the relationship that they establish, asymmetric, they don't know anything about me, but they know that I have a skill set, because every person I ever meet I introduce myself. I introduce the fact that I'm Board-certified in psychiatry and child adolescent psychiatry, that I've worked 40 years or 35 years, that I have been in an academic position, and then I give them my card.

So there's an introduction, and then they start to talk about what they're troubled with. And if they say that their primary problem is that they're the opposite sex, I will say, "Are there other things that are more troubling to you?"

If they say yes, then we address those things. If they say no, then we address that. And the way we address that is we have to combine other evidence-based therapies because there is no single, there is no series of evidence-based treatments for someone claiming gender dysphoria. So what you do is you make a complex evidence-based treatment based on the principles of someone being able to talk, someone being able to listen, someone being able to share observations so that the person can see how they're being experienced by somebody else.

So I'm a neutral, asymmetric person, and I'm sharing observations in a nonthreatening way. But people will get upset. People will get angry. People will cry. People will get depressed. But as you move closer and closer to the self, the self is never harmed, except in psychosis. Okay. But in gender dysphoria, the self remains. And what you do is you slowly have them move towards themselves so that they can understand what they're doing.

And if I, and I have, had patients that complete therapy by acknowledging I am not the opposite sex, but I do want to be the opposite sex, but then at that point the therapy is over. They -- you took care of their comorbidities. They've been restored to themselves. They still have this idea, this whim, this notion that they're the opposite sex, but they're comfortable, they know how to be safe in the community, they're sleeping well, they're eating well, they're taking care of themselves, and their pharmacologic treatment is over, and they're okay.

And the therapy then, the treatment then is over. And if they leave the office with less comorbidities, with treated psychiatric illness and they still believe this notion that they're the opposite sex, but they're functioning, they're not dysfunctional, then the therapy is over, and maybe they call you back to see you again for a short period of time or maybe they don't. But they go on with their life.

Q. Is the therapy that you've been describing, in your opinion, based on your understanding of the California statute, banned in California?

A. Yes.

Q. So what you've just described, you could

not -- legally that therapy is not a therapy that you could legally provide to a client if you wanted to in California?

MR. GANNAN: Objection. Asked and answered. Calls for a legal conclusion.

A. I don't see clients.

BY MR. WILLIAMS:

Q. Patients. I'm sorry.

A. The reason they're called patients is because it's patiens, and it's from Latin, and it means to suffer. And I see people that come in in pain and suffering, and so that kind of treatment, my understanding of the ban in California is that I'm not able to do that kind of treatment.

Q. I was just conflating yesterday with today because psychologists refer to them as clients and not as patients.

A. Because psychologists are not physicians.

Q. Right.

A. And they do deal with pain and suffering, but they don't have patients, any more than a pharmacist has patients.

Q. I agree. Okay.

Have you compared the Tampa ordinance with the California statute?

A. No.

Q. So you don't know what's the same or what's not the same, do you?

A. No, I don't.

Q. Are there physicians, psychiatrists or otherwise, who specialize in treating transgender patients, period?

A. Ironically, it's at the LGBT clinics. They're allowed to do whatever they want.

Q. I'm not following you. I'm sorry. Please explain it.

A. The ban only applies to people like me, but if you are at a clinic that specializes in treating gays, lesbians, bisexuals, transgenders, you are allowed to do whatever you want.

Q. In California?

A. In California. And I have referred -- many people, I say -- you know, they get upset, they want to know if I'm gay, and I don't answer, and I say, "What, what if I am? What if I'm not? How would that" -- I end up saying, "Okay, I get it. You can go to West Hollywood. You can go to this clinic. They -- you can trust the person because they will be gay, they will be lesbian, they will be bisexual, they may be a transgender, and it seems like that is a priority for

you, so I will refer you there."
Q. And these are clinics that hold themselves out to be clinics for gay, lesbian, bisexual human beings?
A. Yes.
Q. Solely?
A. Yeah.
Q. Restricted, that's their population?
A. Yeah.
Q. And what you are testifying to, at least your understanding, is that those gay, lesbian, bisexual clinics can provide therapy that you can't provide under the California statute?
MR. GANNAN: Objection. Calls for a legal conclusion.
A. I think what they do is they skirt the law. They do provide treatment, but they don't acknowledge the difficulties that are inherent in being transgender. They accept it, they affirm it, and they chat and talk. From what I've been told by people that have been at those clinics, it's not really therapy. It's just everybody high-fiving because they're gay, they're lesbian, they're bisexual, or transgender.
BY MR. WILLIAMS:
Q. As opposed to I will just use the word "clinic" that is not focused on gay, lesbian,

bisexuals?
A. Yes.
Q. That clinic wouldn't be doing that, what you just described. Would you agree?
A. Right.
Q. And therein lies the difference, if I understand your testimony?
A. Yes.
Q. Have you ever assisted someone who is going through gender transition?
MR. GANNAN: Objection. Vague.
A. I'm not allowed to be involved in that process. I went to the children's hospital in Los Angeles -- I'm sorry -- I went to the children's hospital in Los Angeles where they do transgender, that kind of stuff, and they weren't interested. I had to affirm. I had to -- I just -- I could not be a doctor to those people in that situation.
BY MR. WILLIAMS:
Q. Because of the statute out there?
A. Yes.
Q. So your answer is really, no, you haven't, you know, as a physician assisted a person in that process that's undergoing gender transition?
A. I've had referrals on people that are on

puberty blockers, on cross-sex hormones and have undergone surgery, not many, but I have had referrals where the patient on their own decides that they're still suffering from some particular psychiatric problem and they've come to me while they've been in that process because they're not getting the help that they want from the other clinic.
I would also like to add that no one on this earth has ever transitioned.
Q. What does that mean?
A. It's what your word is using, and I'm saying that no one has transitioned. There are no such things as transsexuals. No one can become the opposite sex.
Q. I see. So you are using the term "transition" from one sex to the other sex? Is that what you are saying?
A. That's what they say.
Q. Yeah. Okay. That's what I understand. So if that's the case -- I'm trying to think how to articulate this, Doctor. Can you explain for us what causes a male human being to identify as a female human being?
MR. GANNAN: Objection.
A. No.
MR. GANNAN: Object. Vague. Calls for

speculation.
A. No.
BY MR. WILLIAMS:
Q. Why not?
A. It's not known. I have had patients that told me with a straight face that they knew when they were born that they were the opposite sex, before language. It approaches a level of ridiculousness with some of these people, and I find myself saying, "Calm down. Answer the questions. Provide the science. Work with them, but okay. They knew when they were born that they were the opposite sex."
Q. Going back to one of your recent answers that gender transition is just not possible, then -- and I think you said that?
A. Yeah.
Q. Then --
A. I said that no one can become the opposite sex. Gender is -- goes all over the place. People can be very masculine. People can be very feminine. People can be a combination of both, and I think I stated in my declaration that I've never met anyone that doesn't have masculine and feminine qualities.
Q. Well, I think what you did say is you can't transition from one to the other. That's --

A. Biologically, there's no way to reverse billions and billions of chemical reactions so that you have different genes, different chromosomes, different nucleus, different receptors, et cetera.
Q. And if that's the case -- and I accept your testimony at face value -- then it follows that, if gender transition is impossible for the reasons you just articulated --
A. No. Biological sex cannot be transitioned. Everybody's occasionally masculine, feminine.
Q. Is there any -- ever a situation where some effort to transition from one sex to the other is medically necessary to save a life, to do anything of that nature?
A. No.
Q. Have you been faced with a situation where -- I'll focus out in California -- where a patient presents with gender dysphoria and, because of the statute, you were unable to provide any therapeutic modality -- I hope that's a word, a phrase -- at all?
MR. GANNAN: Objection. Vague. Misstates testimony. Calls for legal conclusion.
A. I have treated people in violation of the ban. They will show up for an initial appointment, and they will be at risk for suicide. They will be intoxicated

because of substance use. They will be floridly psychotic. They will have extraordinary panic attacks. They will be massively depressed, and I believe that's an emergency, and I will initiate treatment. I will initiate hospitalization. I will call the team that comes out to evaluate whether someone needs to be hospitalized. I believe that in certain situations affirmation is absolutely totally wrong because it's an emergency, and so I have treated people in that situation.
Q. And that situation would be defined as an emergent situation?
A. As I determine it, yes.
Q. Your judgment that it is an emergent situation?
A. Yes.
Q. And I guess that it follows that if you determined that it was an emergent situation, you also reached the conclusion that, if I do not take these steps, this person could perhaps die?
A. Yes.
Q. Do you know whether the California statute allowed for that in a carve-out for emergencies?
MR. GANNAN: Objection. Calls for legal conclusion.

A. I don't know specifically. I just know that I'm not going to not treat.
BY MR. WILLIAMS:
Q. I follow you. I follow you. You have used the term "affirm" a number of times during your deposition today. Do you know what the American Medical Association's position on affirming a transgender person's gender identity is?
A. No.
Q. Tell me whether or not you agree with the following statement: "Affirming a transgender person's gender identity is an important means of improving health that comes from the transgender population."
Do you agree with that?
A. No.
Q. Why not?
A. It interferes with treatment. It interferes with diagnosis. It prevents you from talking with the person.
Q. So if that's the case, is it your view or your opinion, Doctor, that there are no real empirical studies that have -- let me make sure I articulate this correctly -- no empirical studies that have demonstrated the efficacy of gender transition as a therapeutic treatment for transgender people?

A. Can you read it back to me?
Q. Sure.
MR. WILLIAMS: Please.
(The question was read back.)
A. I'm not sure if you want a yes-or-no answer.
BY MR. WILLIAMS:
Q. I just want the best answer you can provide to me.
A. All right. We know from longitudinal studies that individuals that undergo this kind of process continue to suffer from enormous numbers of psychiatric illnesses. We have multiple instances of individuals going through this kind of process and continuing to suffer from depression, anxiety, substance abuse, suicidal attempts, suicidal actions, self-harm.
What I understand from conferences and colleagues over the years, that the wealthy do fairly well when they have these kinds of hormone therapy and treatments because it's extremely expensive and you become a patient for life. But the poor, for which I've worked most of my life for, suffer enormously. They're not able to access the kind of doctors that do that kind of thing. They're not able to access the hormones, the cost.
But I know from my experience at Vanderbilt

that there are people that have enormous amounts of money and they can access, they can fly to different states and get treatment. But the individuals that I've worked with, my experience says these people, they suffer enormously because they'll start something but they can't continue it or the insurance denies it or their job changes and they get different insurance, and it's a very complicated process for them.

And I know that there are clinics around the country that select certain people for certain procedures, and I know that there are -- there are clinics, I don't know specifically which ones, but I know that there are clinics, not only in this country but in Canada and the UK, that 100 percent of the people that show up are transitioned and are placed on hormones. There is no attempt to differentiate those who may align with their biological sex eventually and those who won't align.

So my answer is that in my experience in two states, Tennessee and California, I have seen wealthy people do pretty well, but I've not seen lower-income people do as well.

Q. All right. Do you have an opinion as to whether or not there's a transition-related care that is necessary for the treatment of transgender persons,

patients?

A. You're asking me if someone that is in the process of taking hormone therapy or cross-sex hormones or having had surgery or all of the above, if they need continued care?

Q. That's certainly part of the question, yes.

A. My answer would be yes.

Q. What about transition-related care that does not involve those components you just identified?

A. If they're not undergoing hormone treatment and they're not expecting surgery, we know that a large percentage of those people will align with their biological sex, and therefore they don't have to have the cost, the expense, and all that for the treatments. They don't become a patient for life.

And if they continue to have other psychiatric problems like depression, anxiety, substance abuse, et cetera, then they would need continued care and treatment.

Q. What evidence do you have that that larger, apparently larger portion of the population you are talking about will align with their biological sex? I think that's what you said. Tell me if I'm wrong.

A. Yeah, I've seen videos, I've seen at conferences, and I've spoken with individuals who are

in pediatrics and other psychiatrists, and I've been told that somewhere between 75, 90 percent of these people will, if given time, will align with their biological sex.

Q. Which means they're no longer in gender transition, I guess?

A. No.

Q. Is my statement correct?

A. I'm sorry. Yes.

Q. Are you a member of the American Medical Association?

A. No.

Q. Have you ever been a member?

A. No.

Q. Why are you not a member?

A. I don't believe in what they say.

Q. Why do you not believe in what they say?

A. I didn't go into medicine to kill people.

Q. And does the American Medical Association endorse killing people?

A. You bet they do.

Q. How so, sir?

A. They high five it every God damn day.

Q. How so?

A. Abortion, assisted suicide, death row.

Q. Death row?

A. Yeah. I'm not part of that. I took the Hippocratic oath. I went to Kos. I walked where Hippocrates walked. I saw the Asclepeion. I believe in that.

Q. Well, correlate what you just said with what we're talking about here, because we're not talking about abortion, we're not talking about suicide or assisted suicide, we're not talking about the death penalty. We're talking about gender dysphoria, gender identity, whatever label people want to use.

I think it's accurate to say that the AMA endorses the necessity of transition-related care for the treatment of transgender persons. Are you aware of that, sir?

MR. GANNAN: Objection. Vague. Assumes facts. Go ahead.

A. I'm aware that many organizations that claim to be professional organizations rah, rah, rah around this issue. You asked me about the AMA. You asked me why I wasn't a member of the AMA. I told you why I wasn't a member of the AMA.

BY MR. WILLIAMS:

Q. You did. I'm asking the question that is pending.

A. I'm responding to the fact that you seem to not understand why I'm not a member of the AMA. I don't know what the AMA policy is about that. I may have read it at one time, but I can be certain that they're for it. Even though it's experimental, investigatory, and there is no long-term studies, they're for it, because they're all for it.

Q. For it, "it" being what? Define that.

A. Transgender, hormone treatment, surgery. They're all -- all the professional organizations are for it.

Q. So I would assume that if the AMA's position is that it endorses transition-related care as a necessary part of treatment for transgender persons, you would disagree with that?

A. I would disagree with that.

Q. Just for your benefit, I think I understand why you are not a member of the AMA. It didn't go by head. I understand that. Whether I agree or not agree is irrelevant, frankly. My opinion doesn't matter. It's your opinion, and that's all that matters.

What I want to try to do, Doctor -- and I'm being very forthright with you -- is to determine and understand your opinions as it relates to your declaration and what your opinions may be if you ever

have to testify at a trial in the case that is before us right now, the Tampa case, so don't think I'm not listening carefully because I am.

A. And don't think I'm not honest.

Q. I don't think that at all.

A. Then don't repeat questions to me.

Q. What do you mean?

A. You asked me about the AMA. You asked me why I wasn't a member of the AMA. I told you why I wasn't a member of the AMA, and then you followed that with a question that sounded like you didn't understand why I wasn't a member of the AMA.

Q. You misunderstood my question then.

A. 80 percent of the physicians in this country are not a member of the AMA, and there is a reason.

Q. Okay. That's fine. Paragraph 23 and 24 of your declaration, as I read them, that LGBT persons have a higher rate of mental illness. Did I read that correctly in reading those two paragraphs?

A. LGBT individuals continue to suffer from a variety of mental illnesses.

Q. Do they have higher rates of mental illness than non-LGBT human beings?

A. Yes.

Q. And why is that? What causes that higher

rate? Do you know?

A. I can't specifically say what causes it. I'm just aware that if I have somebody come into my office that's gay, lesbian, bisexual, transgender, I know that I have to ask them other questions. I can't just take it on face value that they're gay, lesbian, bisexual, transgender.

I know from conferences, from discussions with colleagues from grand rounds, from my own training and education, that that group of people have significantly more mental illness than the general population, the cohort. When you take people that are the same age and in the same area and you compare them to the people that are gay, lesbian, bisexual, and transgender, they -- that group tends to have a prevalence of more mental illness, and so it's not that it's not important to me. I want to know because, if I see that person, I want to be able to ask them questions to determine whether or not they have mental illness because I've been told, I've been educated that they do, and my experience is that they do.

And, oftentimes, I'm able to ask them and they'll -- "yes, I do. Yes. I do." So my evaluations are tailored to the person, and I get demographic data as best I can from the person, and what I've

discovered, what I have heard at conferences, what I have read in the literature is that they do have higher rates of mental illness. And as a clinician hoping to treat, hoping to help, I need to be aware of that.

Q. You anecdotally told us about the gentleman in Nashville who went downtown and some guy attacked him because he was gay, I guess. Is that your understanding of that?

A. Yeah, that's how it was described.

Q. Would you reasonably conclude from that anecdotal episode that whoever attacked him was a form discrimination against gays?

MR. GANNAN: Objection. Vague. Calls for speculation.

A. I don't know all the circumstances that are involved in violence. I can tell you from experience that people that are gay, lesbians, bisexual, transgender, they get attacked a lot, verbally, physically, property, and I have -- when I've been able to work with these kinds of patients, I have discovered that there's a whole world out there that does not accept, does not tolerate, and will not put up with what they do and how they do it.

BY MR. WILLIAMS:

Q. You mean, the gay and lesbian people?

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A. Yeah. Gay, lesbian, bisexual, transgender. You know, 97 percent of the world is heterosexual, and there are many parts of the world that it -- it's a death sentence if you -- and I don't want these individuals to have to go through that, but I can't control the world. But I can help them understand that if certain phrases are said, if certain looks happen, if certain actions take place, protect yourself, don't go in by yourself, don't go to certain places. And it helps people.

Q. Don't you think, Doctor, that the discriminatory attitudes that a lot of people apparently have towards gays and lesbians and transgenders and bisexual human beings, as you generally have described, that that more than likely contributes to the higher level of mental illness among the LGBT population in this country?

MR. GANNAN: Objection. Vague. Calls for speculation and misstates testimony. Assumes facts not in evidence.

A. I think it contributes. When you look at nature, it's not only fixed, it's fluid. We're equipped with genes, DNA through evolution, through time that allows us to adjust, adapt, and accommodate to the changing world. But when you are so far removed

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from everyone else, it's really difficult, I think, to navigate.

Many times I've been told by people that are gay, lesbian, bisexual, transgender, that sometimes they just feel lost. They don't know exactly what to do. They don't know how to protect themselves. They just -- they don't know what to do.

But the very act of being involved in that kind of activity, I think lends itself to psychiatric disorders, lends itself to substance abuse disorders. I would agree --

Q. That activity being what? I'm sorry.

A. The acts of being homosexual --

Q. Okay.

A. -- bisexual, transgender. I think --

Q. But you said but you would agree with what? I interrupt you a bit.

A. I would agree that the stigma, that the going out in social areas puts you at risk. There have been people killed because of this kind of thing.

Q. Sure.

A. For no other reason than the fact that that's what they prefer. And I believe that in a civil society people have the right, as long as they're lawful and remain civil, have the right to have the

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kind of life that they want. But even -- even for us that are not part of that group, it can be dangerous anyway.

So my experience tells me that being gay, lesbian, bisexual, transgender brings on psychiatric problems, and the society, the people, their attitudes makes it even worse.

Q. It exacerbates the situation and that exacerbation lends itself to a higher level of mental illness within the LGBT community. Is that what you are saying?

A. It not only exacerbates, but the very activity itself lends itself to psychiatric problems.

Q. Why?

A. There's medical issues. Many of these people are involved in activities that result in substance abuse, sexually transmitted diseases, depression, anxiety. When you add on the fact that society and many societies will not accept them at all, that can exacerbate already existing problems that they have inherent in what they do. And that's not even talking about the medical problems that they have associated with that kind of behavior.

Q. Let me see if I can switch to another part of your declaration. Turn to page 7, and let me make sure

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I put this in context. On page 6 under the topic "There is No Scientific Justification for Banning Evidenced-Based Practice Talk Therapies Who Present with Gender Dysphoria." And then under --

A. Well, 6 is --

Q. Paragraph 6 is B.

A. Oh.

MR. GANNAN: Page 6.

MS. ROBBINS: Page 6.

BY MR. WILLIAMS:

Q. Page 6, I'm sorry. Page 6.

A. Okay.

Q. Little ii, the subtopic is "So-called 'Conversion Therapy' Bans Unscientifically Target and Censor Sound, Evidence-Based Practice Therapies Delivered Through Speech." Top of page 7.

A. Censor?

Q. Well, that's why I'm going to ask you. It didn't make any sense to me, and that's why I'm asking you the question.

A. I missed that. I don't -- I think it's supposed to be "censors."

Q. Should be "targets and censors"?

A. "Bans Unscientifically" -- "Bans Unscientifically" --

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Q. Syntactically it didn't make any sense to me.
A. It doesn't make any sense to me.
Q. So how would you correct, sir?
A. I missed this.
Q. Okay. Well, it's your declaration, and you are under oath, and as I said at the beginning, it's no not gotcha game. I said that to Dr. Rosik. You were here.
So tell me what you meant to say in that roman numeral double little ii.
A. Okay.
Q. Take your time.
A. Can he help me with this?
Q. What do you mean?
MR. GANNAN: I can't assist you with answering the question.
THE WITNESS: Oh, okay. All right. Okay.
BY MR. WILLIAMS:
Q. Just do the best you can.
A. All right. I know what I want it to say. It doesn't say that.
Q. I assumed that when I read it.
A. Thank you.
Q. You are a very smart guy, so...
(A discussion was held off the record.)

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BY MR. WILLIAMS:
Q. Back on the record. Doctor, I've identified -- just to set the stage, I've identified a subtitle that didn't make any sense to me. And that's ii at the top of page 7 which states, as it is in your declaration, "So-Called 'Conversion Therapy' Bans Unscientifically Target and Censor Sound, Evidence-Based Practice Therapy Delivered Through Speech."
When I read that to you, it didn't make any sense to you, and you have now noodled on it. Is that a good word?
A. Yeah.
Q. And now have come up with what I think you intended to say in the first place, but didn't, for whatever reason, catch before you signed and submitted your declaration?
A. Yeah.
Q. Did I say that correctly?
A. Yes. So what I have is "Conversion Therapy Bans and Targets Scientific Evidence-Based Practice Therapies Delivered Through Speech."
Q. Okay. You've eliminated the word "censor" and "sound" altogether, I take it?
A. Yes.

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Q. All right. Would you do me a favor. I'm going to hand you Exhibit 1 to your deposition, and would you make those changes on the official exhibit to your deposition, again, your declaration, Exhibit 1 so that the official exhibit is --
A. I have a red pen. Is that okay?
Q. Yes. It's my red. That's why I gave it to you.
A. All right.
Q. It's easier to read.
A. Do you want me to write it out or --
Q. However you want to do it.
A. I will write it out. I don't print really well.
(A discussion was held off the record.)
BY MR. WILLIAMS:
Q. Would you read into the record the replacement subtitle for little ii at the top of page 7 as you have now rephrased it.
A. "Conversion Therapy Bans and Targets Scientific Evidence-Based Therapies Delivered Through Speech."
Q. All right. Let's go ahead and take a break now.
(A brief recess was taken.)

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BY MR. WILLIAMS:
Q. In paragraph 25 -- did you want to add something?
A. I regret to inform that I've taken a look at this, and I understand it differently now than I did before, and I spoke with --
Q. Before the break?
A. Yes. And as we ended and I started -- I looked at what I had written, and I realized that that's not what I want to say.
Q. All right.
A. And I appreciate you pointing this out and allowing me to correct it, and I did speak with Roger about this, and so I have changed it so that it says finally what I actually want to say.
Q. Let's do it this way, Doctor. I think this is the perfect time to correct mistakes. Nobody is perfect, of course. If you would, at the bottom of page 7, since we don't have much room at the top anymore, write the subtopic that you now believe is the correct subtopic.
A. Leave the top the way it is?
Q. Yes. I'll make a speech on the record to clarify.
(A discussion was held off the record.)

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BY MR. WILLIAMS:
Q. I have in my hands Exhibit 1 to Dr. Hudson's deposition, which is, in fact, his previously filed declaration dated May 7, 2019. Before the break I had a colloquy back and forth -- you remember what that word means, don't you? -- with Dr. Hudson about the typed subtitle, which did not make any sense to me and I don't think it made any sense to him.
He then wanted to correct it, and he did so in red ink at the top above the printed version. Over the break, he reflected further and decided that what he really wanted to say is what I'm going to read into the record right now, which he has printed at the bottom of page 7, and it reads as follows: "The Tampa ordinance bans all scientific evidence-based practice therapies provided through speech?"
Did I say that correctly, sir?
A. Yes.
Q. And what I just articulated is printed in blue at the bottom of page 7 of your declaration, Exhibit 1, and you have initialed it to the right, have you not, sir?
A. Yes.
Q. So does that cover it? I think it does.
Now, before the break, we had some discussions

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about a number things, but it triggered something in my mind from my reading of paragraph 25 of your declaration. If you would look at about two thirds of the way down, paragraph 25, you will see a sentence that says, "Distressed by thoughts that they cannot process, many resign to a distressed LGBT identity."
Do you see that, sir?
A. Yes.
Q. That seemed, at least to me, to be inconsistent with some of your testimony, and maybe I'm wrong. Tell me what you mean by that sentence.
A. I'm referring farther up. "Many of the youth I have encountered who claim LGBT status are confused, depressed, anxious, isolated, using substances, experiencing poor sleep, complain of physical symptoms, and can be self-harming and/or suicidal. They ruminate about peers and what parents will say and do. Highly distressed and uncertain, they seem relieved when I state that they're free to discuss whatever comes into their minds. Some are so anxious they admit to panic attacks when in public and with their peers in school. They remark that there is no one to talk to privately and brood about what to do. Distressed by thoughts that they cannot process, many resign to a distressed LGBT identity."

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The individuals that I see is in some ways a bias population. I don't see LGBT people that do not have psychiatric illness and may have gender dysphoria but are functioning in the community. The group that I see, usually I'm the tertiary provider. The group that I see is not the typical cohort that you would find in the community. I do understand that there are people who are part of the LGBT population that do not require psychiatric services.
And so the group that I see are so -- they ruminate, they're stressed, they don't know what to do, and they become this secret community of highly stressed-out LGBT people, and they don't know what to do because of a law, and many of these individuals interpret the law that says they can't get therapy, because they don't -- they're not attorneys, and even I don't know exactly precisely what the law says. I just know that I've been told not to do this and the medical board may get involved, and I don't know how it's going to be enforced.
So that sentence refers to those individuals that I talk about that come to me acknowledging that there are individuals that are gay, lesbian, bisexual, and transgender that may not need to see a psychiatrist or have no desire to see a psychiatrist because they're

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functioning.
Q. Just fine?
A. Just fine.
Q. Do you have any concept of, if you take the universe of LGBT population, what percentage are getting along just fine?
A. I don't know precisely. But I know that there are people that identify with that group and are functioning well. They work. They have the right to marry. They have the right to adopt. They seem to have been placed in society and they are functioning in a civil way. So they have no reason to see me. So that comment refers to the people that come to me.
Q. And I understand that. My question really, for my own benefit, is: Do you have any idea -- well, let me back up this way.
The people that see you is a subset of the larger LGBT community? Is that a good way to put it?
A. Yes.
Q. And those that come within the ambit of "many resign to a distressed LGBT identity" is as a subset of the subset?
A. Yes.
Q. So my question to you is: Do you have any idea from a proportional point of view how large this

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sub-subset is of the entire LGBT community?
A. I know that through my education and conferences and grand rounds and discussions with other providers that there is a higher rate of mental illness among this group of people.
Q. The subset -- sub-subset of distressed?
A. No, just the LGBT group.
Q. Okay.
A. The subset of those individuals that don't know what to do, are confused, ruminate, have poor sleep, the ones that I have described, that's the subset that I'm referring to. And I don't know what proportion are functioning fine. I don't know what proportion -- I know that there are studies that show that there's higher rates of depression, substance abuse, anxiety disorders, panic attacks, et cetera, but I don't necessarily see those people. I know that they're out there, but I don't know the proportion.
Q. And you use the term "distressed LGBT identity." Are you referring to those LGBT, that portion of the population that is going through these difficult whatever you want to call them?
A. Yeah, what I outlined ahead of that, those are the specific people I'm talking about.
Q. Confusion, depression, anxiety, et cetera, et

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cetera; right?
A. Yes, because I also see people that are part of the LGBT group that have comorbidities, that have a major psychiatric illness, but there's this other group that, because of the ban, they don't know what to do, and some of them interpret the ban against them. They think that they can't see someone, they're not allowed to talk with someone to help their problems, and then I'm thinking that I'm banned from helping people because the ban is a law.
So it's twofold. The possible patient is thinking that they're banned from actually talking to me or they'll get me trouble, and then I'm banned from actually talking with someone and helping them when they actually show up at my office.
Q. Well, members of the LGBT community certainly can have a -- I guess a self-awareness, self-identification as being gay, do they not?
A. Uh-huh.
Q. Is that a "yes"?
A. I'm sorry. Yes.
Q. Do you know what would cause a minor, since that's what the ordinance addresses, to change that self-awareness that self-identification as being gay?
MR. GANNAN: Objection. Vague. Calls for

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speculation.
A. I'm not sure I understand. Can you --
BY MR. WILLIAMS:
Q. If an adolescent -- I'll just call it an adolescent --
A. Okay.
Q. -- is aware and self-identifies as being gay --
A. Right.
Q. -- whether it's lesbian or gay whatever the case may be, would you agree with me that it's possible that -- well, let me rephrase the question.
Is it possible for that person to change to something other than being gay?
MR. GANNAM: Objection. Vague.
You can answer.
A. Yes, it's possible.
BY MR. WILLIAMS:
Q. And how is it possible? What would cause that to take place?
A. I don't know what would cause it to take place, but I have heard reports of people choosing to be part of that group, and I have heard reports of people not being part of that group anymore.
Q. People who have chosen not to be gay anymore

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and are now back to heterosexual?
A. Yes.
Q. Do you have any evidence-based proof of that that you are aware of?
A. No, it's just reports.
Q. Anecdotal reports?
A. Yes.
Q. And you don't know the truth or falsity of those reports, do you?
A. Well, I've spoken with individuals who are part -- who are homosexual, bisexual -- I don't think -- I think it's just homosexual and bisexual who have told me that they have had a friend that was part of that group and they decided that they weren't, and I've been told that people -- there's a curious thing happening. A lot of people in their 40s and 50s are deciding that they are part of that group.
Q. Part of the --
A. The LGBT -- LGB group. And I've been told not many times, but I've been told that individuals that are homosexual or bisexual decided, I don't know how, that they were not part of that group and became heterosexual.
Q. But you don't know how that change-back, so to speak, took place?

A. I don't. I don't. Because they don't come to see me if they -- they just don't come to see me. They may see other people, but I just haven't come across them.

Q. If, in fact, the anecdotes that you've heard that people have -- I'll just use the street language -- changed back to heterosexual after identifying, as you said with the gay community, if that has happened, you don't know what the causal nexus is for that process; is that true?

A. No.

MR. GANNAN: Objection. Vague. Assumes facts.

A. No, I don't.

BY MR. WILLIAMS:

Q. Just for my edification, going back to your comment earlier, can you even speculate as to what would cause that?

MR. GANNAN: I would object. Calls for speculation.

MR. WILLIAMS: It does.

MR. GANNAN: We're getting beyond the scope of the subject matter that Dr. Hudson is presented for. His report deals primarily, and in terms of any specifics, with minors who present with gender

dysphoria or identify as transgender and speaking about lesbian, gay, bisexual minors is getting beyond the scope of what Dr. Hudson is here for.

BY MR. WILLIAMS:

Q. That's a fair objection. So let me modify my question and restrict it to gender dysphoria. They had gender dysphoria and they no longer have gender dysphoria. Do you know what causes that?

A. I can tell you based on some limited reports, I have had patients and families of patients that have restricted social media and the child or the adolescent no longer is involved in that communication around that issue of being transgender and they pull back from that. They no longer claim to be transgender. That's reports from people that I have seen.

Q. Anecdotal reports?

A. Yes.

Q. You are not aware of any evidence-based studies or reports on that, are you?

A. No.

Q. Take a moment, Doctor, to read paragraph 26 of your declaration.

A. I read it.

Q. Ignoring the ordinance that is in force here in Tampa, what do you think an appropriate treatment

for gender dysphoria is?

A. There currently is no evidence-based practice therapy for this disorder. I have treated other psychiatric illnesses associated with gender dysphoria, and I have at times been able to speak with people over a period of time to help them function better.

Q. In civil society?

A. If someone comes in and they tell me that they have a problem but they're doing fine in all areas, then it's not really a problem. They may actually have a diagnosis, but they're functioning well and they're getting along, and so I don't -- I don't feel that they need to be in treatment because they're -- there's no dysfunction.

Q. You made the distinction a little earlier in your testimony about psychologists versus psychiatrists. Psychiatrists obviously being medical doctors, licensed physicians, and because of that they can prescribe medications. I think even in Florida some psychologists can do that now at some levels.

Go ahead.

A. There is no question.

Q. No, there wasn't. You were about to say something.

A. They're restricted. They're able to use

certain medications, and they oftentimes are heavily supervised because they don't have medical training.

Q. Right.

A. I know that there is a movement around the country to have advanced practice nurses take over.

Q. Yes.

A. They have about 4- to 5,000 clinical hours. I had in excess of 30,000 clinical hours, plus I was motivated to do it. And a lot of times other disciplines are not as motivated as some people. So the psychologists, I know they can practice on Indian reservations and in some manpower shortage areas, but they're supervised and they're restricted in what -- in terms of what they can do, because they cannot diagnose medical problems, and I can.

Q. Are there any drugs or medications that you believe are appropriate to treat gender dysphoria?

A. Only the comorbidities.

Q. Not gender dysphoria itself. Is that what you're saying?

A. No.

Q. Is my statement correct?

A. Yes.

Q. That's a segue to paragraph 28. Read that if you would, please. Starts at the bottom of 7, page 7.

Goes to the top of page 8.
A. I have read it.
Q. At the end of that paragraph 28, you use the term "pharmacologic treatment for a variety of psychiatric illnesses." What do you mean by "pharmacological treatment"?
A. Medications that have been FDA approved for the use in treating a psychiatric illness. That is the definition of pharmacologic treatment for psychiatrists or child and adolescent psychiatrists.
Q. Now, read paragraph 32 on page 8.
A. I read it.
Q. My reason for directing your attention to that paragraph, Doctor, I'm a little perplexed as to why you even include it in your declaration. Am I missing something? Is there some meaning that you intended there that perhaps I'm not appreciating?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. Well, I think that 32 is a continuation of what I'm discussing here, about this ordinance and the California ban, is that there are individuals who take it upon themselves to in some manner, publicly or even privately, harm you because -- for whatever reason. I don't -- I don't know the reasons.

I know that in the last, I think in the last 15, 20 years, a number of notable researchers who are involved in the term "transsexuals," the term "transgenders" have been attacked in various ways, either through protests, either through losing their contracts with the clinics that they were running, or being talked about in negative profoundly disturbing ways on social media platforms. And I know that a number -- well, I know at least one for sure that has been banned from a social platform for simply stating the science behind being a transgender.
And so what I'm presenting there is that I had a personal experience. I don't know if this person was male or female. I never got a chance to actually talk with this person.
Q. This is in California, I take it?
A. Yes. I was asked to see this person. I went out to the waiting room, and I privately said to this person, "Are you so and so?" And this person said, "No."
And so I went back to the receptionist, and I asked the receptionist, "Is that the person I'm scheduled to see?" And she said, "Yes." And she says, "No," and the long and the short of it was that, when I finally went back and said, "The receptionist says that

you're the person I'm supposed to see," this person exploded with a string of profanities in front of the entire waiting area, calling me a bigot and a transphobe -- I got so many phobes, I can't carry them around anymore, but she added a couple more, and then stomped out in front of everybody.
And I know from contacts in California that it's happening to some of the people that I have associated with, not friends, but acquaintances at different conferences that there's a movement to humiliate or publicly defame or harm somebody because they don't -- because they think that you're not going to help them or that you are a bigot or you are all the things that they say.
So I included this because this person filed a complaint with the medical board. It wasn't an accusation; it was a complaint. And in talking with the medical board, I had no records to send because I never actually saw the person.
And I talked to my malpractice company, and I said, "Am I allowed to use the preferred name?" And they said, "No, you have to use a legal name. You cannot treat under a preferred name. You have to treat under a legal name. You can't even write a prescription, you can't order labs under a preferred

name."
And at the clinic, people had to provide their birth certificate. So I know that there are some states that are allowing people to change their birth certificate to their gender, not their biological sex. And I know that at the University of Colorado School of Medicine, they've taken the policy is that, when you come into the hospital, you give your gender, you don't give your sex, and it's driving the doctors out of their mind, because you have to know the biological sex of the person because the treatment can be dramatically -- the physical exam -- so I included that as an example of that happening to me, when I had gone out in good faith to try and have someone come back to the office.
Q. Sure. When you say there's a, quote/unquote, movement, are you describing an organized effort by a group of people to intentionally accomplish an objective, or is it just a generalized use of that term?
MR. GANNAN: Objection. Vague.
A. I know that several researchers with decades of experience in this area have lost their position at a university -- two universities -- three that I'm aware of, have had to file lawsuits to get their

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position back for simply sharing the science.
I'm sure you are aware that there are people in this country that do not believe in vaccinations. And there are teenagers that are secretly going to clinics to get the vaccination so they don't get the illness, because we've forgotten what these illnesses used to do to people.
And I know that most -- I know that you are probably aware that there's an increase in illnesses in this country because people are not getting vaccinated. So there's -- when I say "movement," there seems to be press release science, and people follow that stuff, and they'll go on talk shows and say that, you know, you don't need to have this, you don't need to have that.
And this happened to me, and I hadn't done anything. I went out to try and help, and I don't know that there's any big conspiracy. I just know that top name, highly quality researchers have been attacked in terms of job, in terms of clinic and have had to file lawsuits to get their position back.
I know that recently a researcher at Brown University published a paper and got so much flak that the university changed the title of the paper and --
Q. I'm with you. Off the record.

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(A discussion was held off the record.)
BY MR. WILLIAMS:
Q. We're getting close to the end here, Doctor.
In paragraph 33 at the bottom of 8, you also make the comment, "there are many evidence-based practice therapies that could be used to relieve the stress of gender dysphoria."
Can you identify those evidence-based therapies?
A. Again, just saying to somebody, "You can talk about it. You can discuss it," in many instances, that in itself is a relief. I remember, during my internship year, patients in severe pain would require pain medication, and when you approached them and you told them that the pain medication was coming, they relaxed. Just knowing that the pain medication was going to be coming.
So a lot times when these patients come in and meet with me and I tell them that "You can talk about it. You can talk with me. I'm willing to listen, and I'm willing to understand," that in itself will help people. The other aspect of it is that, because they come in with higher rates of mental illness and you start treating the mental illness, they do better, even with their gender dysphoria, because they're not being

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pounded by anxiety disorders and depression and panic attacks and anxiety states.
Q. In paragraph 35 of your declaration, second full sentence you state, "The American Psychological Association (APA) published in 2015 its 'Guidelines for Psychological Practice with Transgender and Gender Nonconforming People,'" and you follow that with a parenthetical, "(APA, 2015)."
Then in paragraph 36, you state -- first sentence, "The APA, 2015 guidelines," which I just alluded to -- "are an explicit attempt to dictate a therapist's affirmation of a client's 'gender identity,' irrespective of the science that reveals that no one can become the opposite sex."
Did I read that correctly?
A. Yes.
Q. Is it your opinion that the APA 2015 guidelines, the purpose underlying those guidelines is to compel a therapist to affirm a patient's gender identity?
A. It pretty much says that.
Q. And I'm asking you, is that your position in terms of what the purpose of that guideline is?
A. I don't follow that particular guideline, but my understanding in reading the guideline is that I am

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supposed to affirm.
Q. That's the American Psychological Association, so to the extent that you're a psychiatrist, how is that relevant to your practice?
A. It's relevant in the sense that it's one more organization that is coming forth with what they call guidelines, and in my four-decade career, I have seen guidelines become mandated by insurance companies, become standards of care with no evidence, and so it's another reminder that this process is starting to become press-release science.
Q. Well, since you've used again the phrase "evidence-based," if a patient comes to you, Doctor, and you have a consultation and they tell you that they have a gender identity that is different from their birth sex, is there a response you can give that is evidence-based practice therapy?
A. Not for gender dysphoria.
Q. Gender identity, do you distinguish between the two in that question?
A. Everybody has a gender identity. Sometimes it's feminine. Sometimes it's masculine. Sometimes it's a combination of the two. Sometimes -- I mean, I think most people will recognize, even around the world, that masculinity and femininity are -- that move

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back and forth, shift and change.
So gender has for thousands of years referred to biological sex. It's been separated and -- but the definition remains the same: Masculine and feminine.
So if somebody comes in and says they're more feminine and they're male and they more feminine, that's not a psychiatric illness. That's not a reason to be in treatment, unless they start to tell me other things related to that.
Q. Paragraph 37 of your declaration you say, among other things, "It is perverse to ban a possible therapy that will for a majority of children help them reharmonize with their biological sex." Is that a correct statement what I just said?
A. I'm finding it. 37; right?
Q. Yes, sir. Six lines down.
A. Okay. I've read it.
Q. How would you, as a clinical psychiatrist, seek to help a child to reharmonize with his or her biological sex?
A. As I've mentioned in the declaration and as we've talked about. Children as opposed to adolescents -- or if you want me to include children and adolescents, I can do that -- but children that come in oftentimes come in in very chaotic situations.

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There may be problems in the family. There may be problems at school. There may be problems in the community. There may be domestic violence. There may be substance abuse among the parents. I don't -- I don't find -- and, remember, I see a select population -- I don't find that when I -- when they finally come to me that everything is beautiful and light and all that kind of stuff.
I find that there is a lot of problems, not only in the home environment, but they're having problems in the school environment, and they're having problems in the community. And they have oftentimes psychiatric illness as well.
And so as you work with them, as you alleviate those problems, as you alleviate those problems, as you talk with the parents and begin to help them solve those problems, you attenuate the urgency, you attenuate the symptoms, and that in itself will alleviate -- for a lot of children, will alleviate the problems that they're experiencing.
Q. Is that a therapeutic procedure that you just described?
A. If they have an anxiety disorder, you can use an evidence-based anxiety treatment. If they have a depressive disorder, you can use an evidence-based, and

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so the goal -- the goal is not -- there are some illnesses that you just simply cannot cure.
My dad died last year from Parkinson's, and my mom took care of him the last four, five years 7/24, and she's fretting that she couldn't -- she could've done more, and I keep telling her, "Mom, it's a fatal illness. You did as much as you could."
So what I do is try to alleviate the stuff that's happening to them so that they can stand up. Because a lot them come in and they're on the ground. The weight of all this stuff is just pushing them down.
So if you can alleviate the anxiety disorder, if you can get the parents to stop drinking and stop smoking and that, if you can make things so that the child can feel safe again and not threatened again, what you find is that their symptoms attenuate and they're not as bald and they're not as argumentative and they're not as behaviorally disturbed.
Q. Drinking and smoking aside, if, for example, parents were telling their child, "Don't use a name different from your biological sex," you know, something of that ilk, would you ever advise them not to do that or to do that?
MR. GANNAN: Objection. Vague.
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BY MR. WILLIAMS:
Q. The parents. To alleviate the dysphoria, I guess.
MR. GANNAN: Objection. Vague. Incomplete hypothetical.
A. My goal is to render relief where I can most see relief. And if they come in and they're saying that the person has to say this name, I might ask, "What does it say on the birth certificate. What -- how was the decision made to name that child? Is it a family? Is it a friend? I explore the origins of giving that child the name." And that sometimes helps families to understand what is going on. It doesn't cure. It just relieves.
BY MR. WILLIAMS:
Q. We've spent a better part of a day talking about this, Doctor, and I appreciate you educating me as much as anything else without sending me to medical school.
I've gleaned from your testimony, though, that the field of transgender or gender nonconforming is a rapidly changing area of medicine. Would that be an accurate statement?
A. No.
Q. If I eliminate the word "rapidly," would it be

an accurate statement?
A. No.
Q. Correct me, then. What is wrong with my statement?
A. There is a apart of medicine that is moving away from what medicine used to do and used to do really well, and they are using medical treatments, pure medical treatments on a psychiatric condition, and they are springing up all over the country. Academic centers are finding that this is a financial industry.
They're charging thousands and thousands of dollars to these people, and they're taking these children and these adolescents, without any way of knowing which ones will eventually align with their biological sex, and they're treating them with hormones and surgery and making a patient for life.
My understanding of medicine was to relieve pain and suffering and at all costs to seek a cure so that you didn't have the patient anymore. But the pharmaceutical companies are making a lot of money, and a lot these clinics, it's a packaged deal. You buy the hormones from the package deal.
And I have sat in at the Los Angeles Children Center and listened to a pediatrician talk about puberty blockers and cross-sex hormones and surgery on

young children, and I say to myself, "I've spent my entire career working with juveniles in confinement who the courts say cannot understand that they killed somebody, cannot understand that they committed robbery, cannot understand what they did and therefore they cannot be given the death sentence and they cannot be given a life sentence because they're cognitively immature, and yet I am seeing children and adolescents that are being put on treatments that are extremely experimental, and being told that the kid knows that this is okay and that the kid can give consent. I can't balance those two things out.
If you commit a crime, you're too immature to understand that you committed a crime, but if you claim that you are the opposite sex, which cannot happen, you are mature enough to take puberty blockers, surgery, and cross-sex hormones. It doesn't make sense to me.
And given the fact that puberty is the maturation of the human body into adulthood and it takes anywhere from eight to ten years and can go into the early 20s, what are they doing? Maybe that's a little too honest. It just -- it scares me.
Q. Have you in all your years of dealing with gender dysphoria, gender identity matters and issues, have you reached any conclusions as to, A, whether

there is a pervasive discrimination against people who are experiencing that and, B, what impact, if that discrimination exists, it would have on that population in terms of dealing with their gender dysphoria or gender identity?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. There's two questions, and can she read back the first question.
BY MR. WILLIAMS:
Q. Sure.
(Part of the question was read back as follows:
Have you in all your years of dealing with gender dysphoria, gender identity matters and issues, have you reached any conclusions as to, A, whether there is a pervasive discrimination against people who are experiencing that --)
A. Worldwide, people that have claimed to be homosexual, bisexual, transgender, worldwide, people don't get along with them.
When I was in elementary school, there was an individual that we knew was not like us males. He always played with the girls. He had nonmasculine -- we knew that something -- but we didn't harm him. We included him, but we knew that there was something

different, and we didn't know -- I didn't know what it was. I just knew that he wasn't like me and he wasn't like my friends and he wasn't -- he didn't play baseball. He didn't play sports.
You go out in the world, and almost everyone is heterosexual, and you're not. But you go out into West Hollywood, and you are fine. You go into parts of San Francisco, and you're fine. You go out into parts of New York, and you're fine. But you go outside those areas and the world, you're not fine.
So I don't -- I don't think it's pervasive discrimination. I think it's just -- you're not like they are, and that is unusual for people.
The other aspect of this is that -- in Darwin's Origin of Species, in the last chapter, he talks about evolutionary change and that genes are designed to be all kinds of things. Life will find a way. And over long periods of time people who practice homosexuality will not propagate their genes, will not mix their genes. There's no way for them biologically in nature to continue, but it's always been there. It's always happened, because people love sex. And it's an enormous gift to us.
But most of the world is not like that, and most of the world will not -- will not accept it. And

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many people will not tolerate it, and so you find that you hook up with a certain few friends or you don't become public.

Q. And because --

A. I haven't answered the second part.

Q. Go ahead, please.

(The second part of the question was read back as follows: And, B, what impact, if that discrimination exists, it would have on that population in terms of dealing with their gender dysphoria or gender identity?)

A. Outside your peer group, outside your neighborhood, outside that areas of the country that are, for the most part, made up of people that are similar or maybe are like you, I think there are episodes of discrimination. I think there are people who don't like it.

In LA County, I had to take every year a computer course called sexual harassment in the workplace. And it was nothing but how to interact with homosexuals, bisexuals, and transgenders. And I remember sitting with the nursing staff, and one of the nurses was saying, "I come here for work, and now I have to use a pronoun, and now I have to work differently than I normally work or I might get fired."

On that sexual harassment, I had to answer questions that I knew were wrong; otherwise, I would -- LA County would get rid of me. "You're a bigot, Hudson. Get the hell out of here."

I help people deal with the world as it is. And there are people that demand that the world change, and I explain to them over time through evidence-based therapies, if I can use them, that the world doesn't negotiate. It is what it is. And it's harsh, and it's rough, and it can get even harsher and rougher if you're not careful.

So I don't think there's pervasive discrimination. I do think there's a stigma attached to this, and a lot of people have a problem with it, and there are people that will take it out either through physical assault, property damage, or targeting a baker in Colorado.

You had another question?

MR. WILLIAMS: I have no further questions.

MR. GANNAN: Dr. Hudson will read and sign.

(A discussion was held off the record.)

MR. WILLIAMS: Before we conclude Dr. Hudson's deposition, Dr. Hudson made hand-printed changes to the subtitle at the top of page 7, and I went through that on the record earlier this afternoon.

And to make it clear, we have taken the document that he made those handwritten changes and have made it the official Exhibit 1 for his deposition. And that is exemplified by the blue tab at the right-hand bottom corner that has the number "1." Okay.

STIPULATION

It was stated by counsel that the exercise of reading and signing the transcript would not be waived.

(WHEREUPON, the taking of the deposition was concluded at 3:20 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

****

I, ELSA HERNANDEZ, FPR, Notary Public, State of Florida, certify that the witness BERNARD HUDSON, M.D., who produced a driver's license for identification, personally appeared before me and was duly sworn.

WITNESS my hand and official seal this date: 30th day of July, 2019.

ELSA HERNANDEZ, FPR
Notary Public, State of Florida
Commission No. FF897203
Expires 9/30/2019

Electronically signed by Elsa Hernandez (401-364-747-9923)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, ELSA HERNANDEZ, FPR, Court Reporter, and Notary Public, do hereby certify that I was authorized to and did stenographically report the deposition of BERNARD HUDSON, M.D.; that a review of the transcript was requested; and that the foregoing transcript, pages 1 through 151, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 10th day of August, 2019.

Elsa Hernandez

ELSA HERNANDEZ, FPR
Notary Public

ERRATA SHEET

IN RE: ROBERT L. VAZZO v. CITY OF TAMPA, FLORIDA
CASE NO: 8:17-cv-02896-WFJ-AAS
DATE TAKEN: July 30, 2019
DEPOSITION OF: BERNARD HUDSON, M.D.

DO NOT WRITE ON THE TRANSCRIPT - ENTER CHANGES HERE

Please sign, date, and return this sheet to our office. If additional lines are required for corrections, attach additional sheets.

At the time of the reading and signing of the deposition, the following changes were noted:

PAGE	LINE	CHANGE	REASON

Under penalties of perjury, I declare that I have read my deposition and that it is true and correct subject to any changes in form or substance entered here.

SIGNATURE OF DEPONENT: _____
DATE: _____

August 12, 2019

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In Re: Vazzo v City of Tampa

Dear Mr. Gannam:

Enclosed please find the original errata page with your copy of the transcript so Dr. Hudson may read and sign. Please have him make whatever changes are necessary on the errata page and sign it. Please make a copy of the errata page and place it in your copy of the transcript. Please then forward the original errata page back to our office at 101 South Franklin Street, Suite 101, Tampa, Florida 33602.

If the errata page is not signed by the witness within 30 days after this letter has been furnished, we will then process the transcript without a signed errata page. If your client wishes to waive their right to read and sign, please have her sign on the signature line at the bottom of this letter and send it back to our office.

Your prompt attention to this matter is appreciated.

Sincerely,

Elsa Hernandez, FPR
Anthem Reporting

I do hereby waive my signature

_____
BERNARD HUDSON, M.D.

Cc: Robert V. Williams

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc., et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 8:17-cv-2896-T-02AAS
	)	
CITY OF TAMPA, FLORIDA,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF BERNARD O. HUDSON MD

I, Dr. Bernard O. Hudson, hereby declare as follows:

TABLE OF CONTENTS

I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of Plaintiffs. I have been asked to offer my analysis and opinions regarding the claimed scientific justifications for City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (hereinafter "Ordinance 2017-47"), specifically with respect to 'gender identity'. The facts in this Declaration are true and correct and if called upon to testify to them I would and could do so competently.

2. I have studied and practiced medical science since 1979 as a physician who specializes in psychiatry and sub-specializes in child and adolescent psychiatry, with additional expertise in psychiatric illness and treatment of juveniles in confinement. I am board certified in General Psychiatry, 1989, and Child and Adolescent Psychiatry, 1993, by the American Board of Psychiatry and Neurology; and by the National Board of Physicians and Surgeons, 2017, in General Psychiatry and Child and Adolescent Psychiatry. I have recently retired my license with the California Medical Board, having been licensed since 1985; and I am currently licensed, since 1992, with the Tennessee Health Related Board, and with the United States Drug Enforcement Agency. At the end of 2017, I retired from Los Angeles County, Department of Mental Health, Juvenile Justice Division, after 15 years. I have practiced in Wisconsin, California, Kentucky, and Tennessee. While having practiced in academic settings, I am primarily a clinician and teacher.

3. I attended the University of California, San Diego, graduating with a BS in Chemistry and serving as a teaching assistant in Biology, Chemistry, and English Literature.

4. At the Cardinal Stritch School of Medicine, Loyola University, a three-year medical school, I entered the specialty of Psychiatry. I completed my internship and residency in Psychiatry at the Medical College of Wisconsin. I completed my fellowship in Child and Adolescent Psychiatry at the University of California, Davis, School of Medicine, where I worked with Robert Dorn MD, who had been psychoanalyzed by and worked with Anna Freud MD, in London.

5. I have worked in my medical speciality, Psychiatry, and sub-speciality, Child and Adolescent Psychiatry, over the past four decades in a variety of community settings: private practice, two jails, five juvenile halls, and eight camps; two academic appointments, as a Clinical Instructor of Psychiatry, University Of California, Davis, and as an Assistant Professor of Psychiatry, Vanderbilt University School of Medicine; and with the United States Department of Justice, Civil Rights Division, Special Litigation Section, investigating juvenile detention centers in Louisiana and Georgia as an expert witness regarding local and regional community psychiatric standards of care.

6. While working for Los Angeles County, Department of Mental Health, Juvenile Justice Division, I was the designated teacher/instructor for the Department of Justice from 2005 to 2015, teaching Health Services, Mental Health Services, and Probation Services. The instruction was regarding psychiatric illness and treatment and suicide prevention strategies for juveniles in confinement.

7. Attached hereto as Exhibit A is a copy of my curriculum vitae. I have not authored any publications in the previous ten years, and I have not testified at trial or by deposition in any case during the previous four years.

8. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Exhibit B.

9. My compensation for this engagement will be $450 per hour for deposition and trial testimony, $200 per hour for travel time, and actual expenses. I provide the remainder of my time for this engagement *pro bono*.

II. SUMMARY OF OPINIONS.

10. **My opinions regarding the lack of scientific justification for** Ordinance 2017-47 may be summarized as follows:

First, biological sex is male and female, and gender is masculine and feminine.

Second, no one can change from a male to a female or a female to a male.

Third, a significant majority of people identifying as 'transgender' suffer from gender dysphoria, as well as significant mental illnesses such as depression, anxiety, substance-related disorders, self-harm, suicidal ideation and behaviors, and suicidal intent and attempts, etc.

Fourth, so-called 'conversion therapy' bans such as Tampa Ordinance 2017-47, target and censor scientifically sound, evidence-based practice therapies, consisting of speech, and ethically utilized by many medical professionals with minor patients.

Fifth, professional organizations are issuing 'affirming' therapy guidelines that disregard evidence-based practice therapies in favor of ideologically predetermined outcomes for patients suffering from gender dysphoria.

Sixth, because the vast majority of minors who experience gender dysphoria come to accept and psychologically align with their biological sex as they age into adulthood, 'affirming' every minor who identifies as 'transgender' is poor, unscientific practice, and condemns many minors who otherwise would not persist in a 'transgender' identity in adulthood to sterilization and a future of being life-long mental health patients with the attendant costs and risks of harm.

Seventh, there is an increasing number of ethical medical professionals who fear losing their licenses and careers by running afoul of so-called 'conversion therapy' bans and "affirming" therapy dictates.

III. ANALYSIS AND OPINIONS.

A. Preliminary Scientific Considerations.

i. Science and the Scientific Method or Principles.

11. Science is the systematic structuring of knowledge regarding the natural world that can be tested, explained, and predicted, assessing the interior and exterior universe. Empirical knowledge is based on that which is verified from experience, observation, and testing. Science does not answer the question "why?" but rather "how?"

12. The scientific method—or scientific principles—consists of an instrumental injunction, an accepted apprehension, and a common verity. This method can be used to describe causal relations (e.g., biology), or phenomenological/experiential events or connections (e.g., psychology). While many methods are described, the ongoing, continuous observations of the natural world involve characterizations, conjecturing or hypothesis, measurements, inductive and deductive reasoned predictions, experiments, and peer review; and rigorous, assiduous, replicated retesting of all the steps are of necessity.

ii. The Scientific Basis for Sex.

13. In taxonomy, Homo sapiens is the only living human species. Homo sapiens are male and female; there is no other. All of medical science regarding the diagnosis and treatment of humans is based on this understanding. Any abnormal change in the causal biological development of a male or female human being is considered a state of disease.

14. A natal male has sex chromosomes X and Y. A natal female has X and X, and given the redundancy of genetic information in a cell with two X's, in all somatic cells in a female one X is randomly inactivated, according to the Lyon hypothesis, becoming a Barr body. In men with Klinefelter's Syndrome, chromosomal XXY karyotype, there is one Barr body, and in females with chromosomal XXX karyotype, trisomy X, two Barr bodies are noted in the nucleus. Females with Turner Syndrome, chromosomal XO karyotype, do not have a Barr body, as inactivation of the only X chromosome would render the cell without DNA.

15. Gene mutations do occur, biochemical reactions do go wrong, and substances may interfere with normal development, but there has never been a description in all of human medical science describing anyone changing into the opposite sex, changing his or her sex chromosomes, or being a natal male and having a Barr body in the nucleus of his somatic cells.

16. In short, there is no **causal** science to the claim that a man can become a woman or a woman can become a man. Hence, from the genes in the DNA, to the nucleus in a cell, to the cell, to the tissue, to the organs throughout, to the organ system, and to the organism: a male is a male and cannot become a female, and a female is a female and cannot become a male. No causal science exists in the medical literature to refute this fact.

17. Males and females have a biological place that is not reversible. The propagation and mixing of genes to provide an organism with new living opportunities in its environment, is only possible in humans when a sperm, from a male, and an egg, from a female, combine to bring

together varied genotypes and ensuing phenotypes to produce a human being. During four decades of medical practice, no patient of mine has ever provided evidence that he or she had changed from one sex to the opposite sex. Some have identified as the opposite sex based on subjective thoughts and feelings, but none has ever provided objective or causal evidence that his or her DNA is now composed of genes of the opposite sex.

iii. The Recent Division of Gender and 'Gender Identity' from Sex.

18. The definition of gender has traditionally referred to the sex-related categories of masculinity or femininity. The history of the terminology of 'gender identity' has only varied over the last half century. The idea that gender is unrelated to biological sex came from John Money's concept of gender role, made public in the late 1950's. He conceived of a gender distinct from biological sex. He offered the idea, but with no evidence except in those rare individuals who suffered from abnormal development. (Money, 1955; Money, Hampson, & Hampson, 1957). Haig (2004) describes the evolution of the change in definition of gender in the article, "The Inexorable Rise in Gender and the Decline of Sex: Social Change in Academic Titles." As Haig describes, the loss of the definition of gender did not become a widespread issue until early feminist's began to use the term in the 1970's to differentiate themselves socially from males. (Lindsey, 2010).

19. The World Health Organization (WHO) (2017) recently stated on its website that sex categories are male and female while gender refers to masculine and feminine. 'Gender identity' is related to characteristics that are more or less masculine or feminine, but sex is differentiated, for example, by males with testes and females with ovaries; males have heavier bones, and females can menstruate. Thus, 'gender identity' is considered variable in individuals, but sex is immutable in all individuals. (WHO, 2017).

iv. Evidence-Based Practice Therapies.

20. There are various types of therapy for parents and children/adolescents, including cognitive behavioral, dialectical behavioral, interpersonal, psychodynamic, psychoanalytic, mindfulness, family, play, marriage and family, and psychotherapy. Not all therapies, however, constitute evidence-based practice. Evidence-based practice therapies adhere to psychological techniques which are scientifically based. Both the American Psychiatric Association and the American Psychological Association consider evidence-based practice therapies to be preferred approaches for symptom relief. (Emmelkamp, et al., 2014; Cook, Schwartz, & Kaslow, 2017; McNair, Woodrow, & Hare 2017; Sackett, et al.,1996; Spring, 2007; Blow & Karam, 2017; Kraus, et al., 2016; Linehan, et al., 1999; Vigerland, et al., 2016).

21. Since there are several kinds of evidence-based practice therapies, choosing the correct one is dependent on which one will best help the suffering patient. Patients with eating disorders, depression, intellectual disabilities, marital issues, etc. will require a combination of therapies as the symptoms lessen or worsen. As always, the two main goals of evidence-based practice therapy are the quality of the treatment to lessen the symptom load and the increasing accountability of the therapy by the patient to work to solve their dysfunction, aided by a qualified therapist using evidence-based practice.

22. What is not present in any literature search are evidence-based practice therapies for someone identifying as 'transgender'. There is phenomenological/experiential science that identifies a psychiatric disorder called gender dysphoria in those claiming to be 'transgender'. The use of opposite-sex hormones in those individuals with gender dysphoria does not change DNA, chromosomes, steroid/sex receptors, or Barr bodies in natal females, or add Barr bodies to natal males; nor muscle strength, bone density, organs throughout the body, or biological sex. A male may believe he is a female and vice versa, but in Homo sapiens biological sex does not change. In reality, neither opposite sex hormones nor surgical alteration of healthy tissue changes anyone into the opposite sex.

B. There Is No Scientific Justification for Banning Evidence-Based Practice Talk Therapies for Minors Who Present with Gender Dysphoria.

i. Children and Adolescents Who Identify as LGBT Are at A Substantially Higher Risk of Mental Illness Requiring Treatment.

23. Human sexuality is extraordinarily diverse. The LGBT acronym includes people who have expressed non-conventional sexual orientations or identities. Currently the state of knowledge regarding LGBT people is expected to be extended in the next few decades as society continues to become more accepting of this population. But despite this increasingly widespread social acceptance, LGBT individuals continue to suffer from a variety of mental illnesses. Many LGBT people are now 'coming out' during adolescence when developmental issues of identity, social acceptance, and strong peer-influence and opinion are most intense. Increasingly, children are claiming sexual identities at ever younger ages.

24. A study in the United States indicates that over 95% of the US population is heterosexual. (Gates, 2011). World-wide estimates of heterosexuality are essentially the same, some slightly less and some slightly more. During this period, studies have shown that past-year mental health diagnosis among youth indicate that 10% have a mood disorder, 25% an anxiety disorder, and 8.3% a substance related disorder. (Kessler, et al., 2012; Kessler, 2007; CDC, 2013). Additionally, suicide is the third leading cause of death for youth ages 10-14 and the second leading cause of death for ages 15-24. (Bostwick, et al., 2010). When LGBT individuals are included, they are at significantly greater risk of poor mental health: elevated risk for depression and mood disorders, anxiety disorders, PTSD, alcohol related disorders, and suicide ideation/intent. (Cochran, Sullivan, & Mays, 2003; Cochran, et al., 2007; Gilman, et al., 2001; Hatzenbuehler, Nolen-Hoeksema, Dovidio, 2009; Burgard, Cochran, Mays, 2005; Needham, 2012). Many studies demonstrate that severe distress, symptoms of mental illness, and behaviors related to these disorders are to be found in the LGBT population well before adulthood. (Fish & Pasley, 2015; Ueno, 2005; Eskin, Kaynak-Demir, & Demir 2005). US and international studies reveal a population with high levels of emotional distress, symptoms related to mood and anxiety disorders, self-harm, suicidal ideation and suicidal behavior compared to heterosexual youth. (Fergusson, et al., 2005; Fleming, et al., 2007; Marshal, et al., 2011).

CONVERSION THERAPY BANS MUST TARGET SCIENTIFIC EVIDENCE-BASED THERAPIES ACCURATELY THROUGH SPEECH. BH

ii. So-Called "Conversion Therapy" Bans Unscientifically Target and Censor Sound, Evidence-Based Practice Therapies Delivered Through Speech.

25. In my experience as a psychiatrist who sub-specializes in child and adolescent psychiatry, the population identifying as LGBT is at significantly greater risk of psychiatric illness and requires treatment—not predetermined goals of "affirmation" or "conversion." Laws that keep patients away from treatment harm these individuals. Laws that purport to ban "conversion" therapies and impose "affirming" therapies are such laws. Many of the youth I have encountered who claim LGBT status are confused, depressed, anxious, isolated, using substances, experiencing poor sleep, complain of physical symptoms, and can be self-harming and/or suicidal. They ruminate about peers and what parents will say and do. Highly distressed and uncertain, they seem relieved when I state that they are free to discuss whatever comes into their minds. Some are so anxious they admit to panic attacks when in public and with their peers in school. They remark that there is no one to talk to privately and brood about what to do. Distressed by thoughts that they cannot process, many resign to a distressed LGBT identity. Conversely, I have encountered minors who appear comfortable with being part of the LGBT group and understand that their peer group may be a source of stress and aggression. In this situation, the discussion centers on how best to handle such instances of stress and bullying or aggression, who to talk with, and how best to organize the therapy to meet their needs as the therapeutic process unfolds.

26. I have diagnosed and treated many individuals suffering from gender dysphoria and sexual instincts that disturb them and cause them significant discomfort. While diagnosing and treating a patient, I will offer educational observations based on my scientific understandings in psychiatry and child and adolescent psychiatry. As with all those who seek relief from pain and suffering, the type of therapy applied depends not on their sexual non-conformity or orientation, but rather on the needs of the patients to alleviate their pain and suffering. As a child and adolescent psychiatrist, I use no therapy that attempts to 'affirm' or 'convert', but rather I attempt to **restore** physical, mental, and civil functioning; a sense of gratitude; improved self-esteem; and an ability to observe oneself and make adjustments and adapt to varying situations. Evidence-based practice therapy for people suffering from gender dysphoria does not harm the patient but aims to help them explore root causes, alleviate their pain and suffering, and assist them with their dysphoria.

27. I and others who ethically practice psychiatry and child and adolescent psychiatry **never engage in physically aversive or verbally coercive treatments, as this kind of treatment is reprehensible, and is lacking in any evidence-based science.** Practices that knowingly attempt to coerce or harm patients have been repudiated by myself and others in my profession for several decades. I have taken the Hippocratic Oath and I have stated publicly that "I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing." My therapy is a combination of evidence-based practice, both in terms of therapy through speech and psychopharmacology; and the objective is to heal. I do not harm patients, although therapy can be painful and pharmacologic treatment may have distressing side effects. Apart from occasional court-ordered therapy sessions, therapy is voluntary.

28. In my experience, children and adolescents suffering from gender dysphoria and identifying as 'transgender' presented with varying expectations for therapy. Some presented with a preconceived notion that I must identify as 'gay' in order to help them, and they preconditioned

* THE TAMPA ORDINANCE BANS ALL SCIENTIFIC EVIDENCE-BASED PRACTICE THERAPIES PROVIDED THROUGH SPEECH. BH

therapy on my answering that inquiry. Some, though fewer, demanded full affirmation of their 'transgender' identity and/or expression as a precondition to my treating them. The minors I was most able to help, however, presented without preconditions, actively engaged in therapy, came to realize important issues about themselves, experienced a diminishment of their symptoms, admitted they had a better sense of how they became the persons they were, and were grateful for the therapy. In addition to speech-based therapy, this group usually also required pharmacologic treatment for a variety of psychiatric illnesses.

29. Within the group I have tried to help, however, some indicated reticence or doubt about my being able to help them because of California's law against so-called "conversion therapy." I allowed the patients within this group to talk and wonder freely, and the therapy approaches I used, as with all patients, depended on the symptoms presented and the character of the person. Their initial reticence caused by such 'conversion' bans, however, impacted the duration and initial effectiveness of treatment. I also have been told by many patients that they have friends who are afraid to seek help for their distress due to "the law" that prevents any therapist or physician from attempting to "convert them."

30. I am not aware of any evidence-based practice therapy that 'converts' someone from being 'transgender', and 'conversion' is never a therapeutic goal. But California's law, like Tampa's Ordinance 2017-47 banned any therapy approach that might lead to a person's changing from legal definitions of sexual orientation or from a 'transgender' identity. Thus, laws like Tampa's Ordinance 2017-47 negatively impact both practitioners and patients. Practitioners are afraid to provide, or have discontinued providing, psychiatric treatment for psychological pain and suffering related to gender dysphoria and identity because such treatment either violates or could be construed to violate the law against 'conversion therapy'. Patients are afraid to seek, or forego seeking, such therapy for the same reasons. While it was never clear to me how such a ban could ethically or fairly be enforced, or who would be qualified to enforce it, I apprehended that the California Medical Board would withdraw my license if I was found to be afoul of the law.

31. 'Conversion therapy' bans like Tampa's Ordinance 2017-47 impose de facto speech codes that subject practitioners to fear that they could be disciplined for saying the wrong thing. Although ethical practitioners in jurisdictions with such bans desire to provide psychiatric treatment to individuals suffering from gender dysphoria, they are increasingly concerned that treating such patients who identify as 'transgender' would jeopardize their careers.

32. I had a personal experience justifying these fears when an individual who came to a community clinic for treatment became extremely and publicly upset that I used the individual's legal name—for legal and ethical reasons—instead of the individual's preferred name which apparently was attached to the individual's cross-gender identity. This person filed an accusation of misconduct against me with the medical board and, although the case was dismissed and the records destroyed, I sensed how quickly my career could be derailed by simply using someone's legal name in apparent violation of 'affirming' principles.

33. Although the science of treating individuals who identify as 'transgender' is in the early stages of discovery, there are many evidence-based practice therapies that could be used to relieve the distress of gender dysphoria, whatever the direction of change that could occur for any particular patient. But practitioners are reluctant to treat such individuals, or have discontinued

treating such individuals, for fear of actually helping someone who may later a claim a violation of a 'conversion therapy' ban.

iii. So-Called 'Affirming' Therapy Is Not an Evidence-Based Practice and Imposes an Outcome Predetermined by Therapists.

34. So-called "affirmative" therapy, which is promoted by Ordinance 2017-47, is actually not therapy for the patient, but an instruction manual for the therapist to follow to declare and affirm, and how to understand those who identify as 'transgender' or among the gender nonconforming group. But simply affirming people are who they say they are is not diagnosing and not providing treatment or therapy but is instead 'reality nodding'. I have had countless patients inform me of their self-diagnoses, only to discover after further inquiry that their correct diagnoses are different from what they had believed. Hundreds of patients have told me what they believe to be causing their problems, and through therapy they discover that the etiology of their problems is distinctly different from what they had believed. Therapy is for the patient; and most patients drop out of therapy because therapy requires an inward-looking ability, and many will stop due to the difficulty with examining themselves. There is no evidence-based practice therapy specifically for LGBT people, only guidelines for the 'affirming' therapist to be informative, knowledgeable, understanding, sympathetic, and agreeable. But these guidelines are merely a baseline for how any psychiatrist or therapist should interact with anyone who seeks alleviation from pain and suffering. They do not, however, provide evidence-based practice therapy guidance that is needed by the patient to relieve their suffering.

35. Many publications purport to provide guidelines or standards for the therapy of those identifying as 'transgender', but there is no evidence-based practice therapy described in those same publications. The American Psychological Association (APA) published in 2015 its "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" ("APA, 2015"). However, guidelines are not evidence-based practice therapy. The World Professional Association for Transgender Health (WPATH) in 2011 published its "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version" ("WPATH, 2011"). However, standards of care are not evidence-based practice therapy. What is discussed are social stressors, being culturally sensitive, stigma, psychiatric co-morbidities, suicidal ideations and/or suicidal intent, sexually transmitted diseases (STDs), and substance abuse. Busa & Lakshman (2018) authored the article, "A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder." Contrary to its title, however, this article is not a review of evidence-based practice therapy for those identifying as 'transgender'; rather, it is a look into evidence-based practice for anxiety disorders. But the authors recommend that therapists "modify and adapt" their therapeutic approach with 'transgender' youth, which risks invalidating the evidence-based practice justification for the therapy. Another article characteristic of many of this type was authored by Hope, et al. (2016), "Culturally Competent Evidence-Based Behavioral Health Services for the Transgender Community: Progress and Challenges." This article title makes it appear that evidence-based practice therapy is taking place, but what the article actually describes is educating a therapist about how to understand the culture of being a 'transgender' and in "affirming" and "helping to transition."

36. The APA, 2015 guidelines are an explicit attempt to dictate a therapist's affirmation of a client's 'gender identity', irrespective of the science that reveals no one can become the

opposite sex. The article describes sixteen guidelines, the express purpose of which is for a psychologist to become a "trans-affirmative" psychologist. While the article states that guidelines are different from standards, in my experience, guidelines can quickly become standards. And given the possibility that the goals and self-chosen identity of a person who is asking a therapist for help may change over time, and given that no one can yet determine if change will occur in any particular individual, following the guidelines places a client in a situation where the outcome is already determined by the psychologist. To the extent the goal of therapy is 'know thyself', the 'thyself' is already preconceived by the guideline-following psychologist. People come to a mental health provider for many reasons, known and unknown, and to foreclose the possibility that change can occur in a direction not of the provider's choosing limits the person's freedom and autonomy, stalls therapeutic progress, and interferes with the natural course of healing.

37. Those in my profession know that many children will not retain a 'transgender' identity as adults, and that a significant majority will come to accept and psychologically align with their biological sex. (See Meyer-Bahlburg, 2002). Who can say with scientific certainty which child will become a 'transgender' adult and which will not? Banning evidence-based practice therapy is a harm to people seeking help with psychiatric illness; and it is perverse to ban a possible therapy that will for a majority of children help them reharmonize with their biological sex. (See, e.g., Meyer-Bahlburg, 2002, p. 360 (commending "treatment approach that speeds up the fading" of cross-gender behavior in children)). Additionally, there is no currently accepted evidence-based practice therapy for children who claim to be 'transgender'. I spend a significant amount of time working with parents to help them understand what is happening to their children; and this is important for the family to comprehend the diagnosis and the recommended treatment. Automatically affirming a child's claimed identity is not evidence-based practice, but rather a declaration of a future of being a life-long patient, cross-sex hormones, surgical destruction of healthy tissue and surgical side effects, life-long medical costs, and a life-long diagnosis of gender dysphoria with accompanying health problems such as sterility and loss of sexual pleasure. (Cretella, 2018). Any discussion of risk of harm resulting from therapy must include the mounting evidence of life-long potential harms from "affirming" therapy.

38. To affirm patients in denying the realities of their sex and the substantial likelihood of later psychological alignment with that sex is to withhold effective and holistic psychiatric care. This is reality: The practice of psychology and psychiatry is the art of assisting clients/patients with being able to live in the real world, in harmony with the circumstances they find themselves in, and to enjoin with the world in a manner that will allow them to live freely, in a civil way, and to associate with others to the benefit of themselves and society. The guidelines that are put forth by many professional organizations, simply to affirm a patient's denial of reality, is to withhold effective evidence-based practice and individual holistic psychiatric care. But the practice of psychiatry and psychology, at its essence, is the art of assisting patients and clients to live in harmony with reality.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this May 7, 2019.

Bernard Hudson MD

Bernard O. Hudson, M.D.

BERNARD O HUDSON MD

CURRICULUM VITAE

OFFICE TELEPHONE: PRIVATE

DATE AND PLACE OF BIRTH: MARCH 30, 1952
SACRAMENTO, CALIFORNIA

PERSONAL DATA:
MARITAL STATUS MARRIED 05-31-1980
SPOUSE'S NAME MARSHA R HUDSON BS RN
CHILDREN'S DATA KARRIS R HUDSON 10-27-1980
TORRY S HUDSON 02-22-1987
*BRANDON J HUDSON 05-13-1988
*Deceased 07-18-2015

EDUCATION:

UNIVERSITY OF CALIFORNIA, SAN DIEGO
LA JOLLA CALIFORNIA 1975-1979
BACHELOR OF SCIENCE CHEMISTRY

LOYOLA UNIVERSITY
CARDINAL STRITCH SCHOOL OF MEDICINE
CHICAGO ILLINOIS 1979-1982

MEDICAL COLLEGE OF WISCONSIN
MILWAUKEE WISCONSIN 1982-1985
INTERNSHIP/RESIDENCY PSYCHIATRY

UNIVERSITY OF CALIFORNIA, DAVIS
SCHOOL OF MEDICINE
SACRAMENTO CALIFORNIA 1985-1987
C/A PSYCHIATRY FELLOWSHIP

CURRENT CME:

UNIVERSITY OF ARIZONA
COLLEGE OF MEDICINE 09-17, 3 CME

NEUROSCIENCE EDUCATION INSTITUTE
DEPARTMENT OF CONTINUING EDUCATION
11-17, 36 CME

TENNESSEE HEALTH RELATED BOARDS
TRAUMATIC BRAIN INJURY 10-17, 6 CME

EXHIBIT A

PROFESSIONAL EXPERIENCE:

Yolo County Day Treatment Program April 1986-December 1988
Broderick, California
Outpatient program for 8-10 adolescents
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to adolescents.

California Youth Authority April 1987-October 1990
DeWitt Nelson School
Stockton, California
Provided psychiatric evaluations for Parole Board and emergency psychiatric evaluation.

Omnibus Mental Health Group June 1897-September 1991
Davis and Sacramento, California
Clinical practice involving diagnosis and treatment of children, adolescents, and adults. Provided supervision for Psychiatrists; Psychologists; Licensed Clinical Social Workers; Marriage, Family, And Child Counselors; and Master of Social Work Interns.

California Youth Authority April 1987-October 1990
DeWitt Nelson School
Stockton, California
Provided psychiatric evaluations for Parole Board and emergency psychiatric evaluation.

St. Patrick's Home for Children June 1987-September 1991
Sacramento, California
Residential Treatment Facility, 44 Bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Sacramento Children's Home July 1987-July 1991
Sacramento, California
Residential Treatment Facility, 60 bed
Provided psychiatric emergency call and emergency consultation to clinical staff.

Regional Adolescent Treatment Program July 1988-July 1990
Stockton, California
Residential Treatment Facility, 42 bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Serendipity Diagnostic and Treatment Center March 1988-Aug 1988
Citrus Heights, California
Residential Treatment Facility, 38 bed
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to residents.

Regional Adolescent Treatment Program July 1988-July 1990
Stockton, California
Residential Treatment Facility, 42 bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Sacramento County Juvenile Hall Sept 1988-Sept 1991
Sacramento, California
300 Bed Juvenile Detention Center
Provided psychiatric consultation to juvenile detention center administration and clinical staff and diagnosis and treatment to detainees.

F.O.R.M. School December 1988-October 1990
Nevada City, California
Residential Treatment Facility, 48 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Families First January 1989-October 1989
Davis, California
Residential Treatment Facility, 24 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Pine Point, Center, Inc. October 1993-October 1995
Jackson, Tennessee
Juvenile Sexual Offender Program
Medical Director
Residential Treatment Facility, 32 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Pine Point, Center, Inc. February 1994-October 1995
Jackson, Tennessee
Juvenile Sexual Offender Program
Medical Director
Residential Treatment Facility, 16 bed
Provided medical oversight for nursing and clinical staff, quality assurance and improvement for medical services, and diagnosis and treatment for residents.

Hermitage Hall, Inc. October 1996-October 1999
Nashville, Tennessee
Juvenile Sexual Offenders Program
Medical Director
Residential Treatment Program, 95 bed
Provided medical oversight for nursing and clinical staff, quality assurance and improvement for medical services, and diagnosis and treatment for residents.

Dede Wallace School April 1998-January 1999
Nashville, Tennessee
Community Outpatient Clinic
Provided part-time psychiatric diagnosis and treatment to children and adolescents.

Jackson Academy September 1998-March 1999
Dickson, Tennessee
Residential Treatment Facility, 75 bed
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to residents.

Camelot Care Centers, Inc. May 1999-December 1999
Nashville, Tennessee
Consulting Corporate Medical Director
Provided psychiatric consultation to administration regarding medical and mental health standards of practice.

Juvenile Justice Center April 2000-October 2000
Nashville, Tennessee
95 Bed Juvenile Detention Facility
Provided psychiatric consultation to administration, clinical training to probation staff and diagnosis and treatment to detainees.

Los Angeles County Nov 2000-Dec 2002
Department of Mental Health
Juvenile Justice Division
Locum Tenens – Staff Care, Inc.
Provided psychiatric diagnosis and treatment to juvenile hall and camp detainees.

Clinical Counseling Services July 2002-Aug 2004
Los Angeles, California
Community Mental Health Clinic
Provided psychiatric diagnosis and treatment to outpatients.

Los Angeles County January 2003-December 2017 **(RETIRED)**
Department of Mental Health
Juvenile Justice Division
Staff Psychiatrist
Provided psychiatric diagnosis and treatment to juvenile hall and camp detainees.

Centerstone of Tennessee January 2018- December 2018
Frank Luton Center
Staff Psychiatrist
Provided psychiatric diagnosis and treatment to outpatients.

ADULT PSYCHIATRY:

Sacramento County Jail April 1986-September 1988
Sacramento, California
Provided psychiatric diagnosis and treatment to jail inmates on the Forensic Inpatient Unit, a 20 bed acute care setting.

Criminal Justice Center April 2000-December 2000
Nashville, Tennessee
Davidson County Jail
Provided psychiatric diagnosis and treatment to jail inmates.

NATIONAL HEALTH AND SERVICE CORPS:

Bluegrass Mental Health and Mental Retardation Board, Inc. Sept 1991-January 1992
Lexington, Kentucky
Child, Adolescent, and Adult Psychiatry
Temporary Placement
Provided psychiatric consultation to mental health clinic administration and clinical staff and psychiatric diagnosis and treatment to outpatients covering four separate community mental health clinics.

Carey Counseling Center, Inc. November 1992-August 1995
Paris, Tennessee
Child, Adolescent, and Adult Psychiatry
Permanent Placement
Provided psychiatric consultation to mental health clinic administration and clinical staff and psychiatric diagnosis and mental health clinics, a residential treatment facility of 16 beds, and a therapeutic preschool of 12 children.

ACADEMIC APPOINTMENTS:

University of California, Davis School of Medicine July 1987-September 1991
Sacramento, California
Clinical Instructor of Psychiatry

Vanderbilt University School of Medicine August 1995-August 2000
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
Assistant Professor of Psychiatry

Vanderbilt University August 1995-September 1998
School of Medicine
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Psychiatric Hospital at Vanderbilt
Nashville, Tennessee
Clinical Director, Partial Hospitalization Program for Adolescents

Vanderbilt University January 1998-July 2000
School of Medicine
Vanderbilt University Children's Hospital
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
Director, Consultation/Liaison Service

Vanderbilt University 1997-1998
School of Medicine
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
J. E. Dozier Award: Outstanding Teacher in Child and Adolescent Psychiatry

FORENSIC PSYHIATRIC CONSULTATION:

Mississippi Protection and Advocacy, Inc. July 1997-Jan 1998
Jack Bach, JD
Investigation into psychiatric standards at East Mississippi State Hospital.

United States Department of Justice August 1997-Feb 1998
Civil Rights Division
Special Litigation Section
Kevin Russell, JD
Investigation into medical/psychiatric conditions in Georgia's juvenile detention facilities.

United States Department of Justice April 1998-January 2000
Civil Rights Division
Special Litigation Section
Kevin Russell, JD
Investigation into medical/psychiatric conditions in Louisiana juvenile detention facilities.

LICENSURE AND CERTIFICATION:

MEDICAL LICENSURE-

WISCONSIN	25297	07-01-1983	EXPIRED
CALIFORNIA	G55362	07-16-1985	RETIRED 3/31/19
KENTUCKY	TEMPORARY		EXPIRED
TENNESSEE	MD25085		CURRENT

SPECIALTY BOARD CERTIFICATION

GENERAL PSYCHIATRY (ADULT)
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
CERTIFICATION NUMBER 31466
1989

CHILD AND ADOLESCENT PSYCHIATRY
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
CERTIFICATION NUMBER 3269
1993

NATIONAL BOARD OF PHYSCIANS AND SURGEONS
GENERAL PSYCHIATRY (ADULT)
2017

NATIONAL BOARD OF PHYSCIANS AND SURGEONS
CHILD/ADOLESCENT PSYCHIATRY
2017

REFERENCES

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Burgard, S.A., Cochran, S.D., Mays, V.M. (2005). Alcohol and Tobacco Use Patterns Among Heterosexually and Homosexually Experienced California Women. *Drug Alcohol Depend.*, 77, 61–70.

Busa, S., Janssen, A., Lakshman, M. (2018). A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder. *Transgender Health*, 3, 1, 27–33.

Centers for Disease Control and Prevention (CDC). (2013). 10 Leading Causes of Death by Age Group, United States—2013.

City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (and all publications cited therein).

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Cochran, S.D., Sullivan, J.G., Mays, V.M. (2003). Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States. *J. Consult. Clin. Psychol.*, 71, 53–61.

Cook, S.C., Schwartz, A.C., Kaslow, N.J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics*, 14 (3), 537–545. doi:10.1007/s13311-017-0549-4.

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and evidence-based psychological interventions. *International Journal of Methods in Psychiatric Research*, 23 (S1), 58–91.

Eskin, M., Kaynak-Demir, H., Demir, S. (2005). Same-Sex Sexual Orientation, Childhood Sexual Abuse, and Suicidal Behavior in University Students in Turkey. *Arch. Sex. Behav.*, 34, 185–195.

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First Amended Verified Complaint for Declaratory, Preliminary and Permanent Injunctive Relief, and Damages (Doc. 78, June 12, 2018), *Vazzo, et al. v. City of Tampa, Fla.*, No. 8:17-cv-02896-CEH-AAS, U.S. Dist. Ct., M.D. Fla.

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EXHIBIT B

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