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Deposition of:

Norman Spack , M.D.

August 1, 2019

In the Matter of:

Vazzo, Robert L, et al. v. City of Tampa, Florida

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION
Case No.: 8:17-cv-2896-T-02AAS

ROBERT L. VAZZO, LMFT, etc., et al.
Plaintiffs
vs.
CITY OF TAMPA, FLORIDA
Defendant

D E P O S I T I O N
o f
NORMAN SPACK, M.D.

taken on behalf of Plaintiffs

DATE: August 1, 2019

TIME: 11:00 a.m. to 4:13 p.m.

PLACE: Burr & Forman, LLP
201 N. Franklin Street, Suite 3200
Tampa, Florida 33602

BEFORE: Dawn A. Hillier, RMR, CRR, CLR
Notary Public - State of Florida, at Large

APPEARANCES:

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ALSO PRESENT:

Shannon Minter
Dr. Bernard Hudson (via telephone)

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(Exhibits retained by counsel.)

REPORTER'S KEY TO PUNCTUATION:

-- At end of question or answer references interruption.

... References a trail-off by the speaker. No testimony omitted.

"Uh-huh" "Um-hum" References affirmative sound.

"Huh-uh" "Um-um" References negative sound.

NORMAN SPACK, M.D.

was called as a witness and having first been duly sworn, responding "I do," was examined and testified as follows:

COURT REPORTER: Thank you.

DIRECT EXAMINATION

BY MR. GANNAM:

Q Good morning, Dr. Spack. My name is Roger Gannam and I'm an attorney for the plaintiffs in the lawsuit against the City of Tampa regarding its ban on conversion therapy as its local ordinance. And we're here to take your deposition today in the capacity as a an expert witness for the City of Tampa. Am I correct so far?

A Correct.

Q Great. I want to go through a few ground rules and then we'll get into it. Have you had your deposition taken before?

A Yes, actually.

Q Okay. Some of this may sound familiar, then. But we're going to be taking down everything stenographically today, every word. So it's important that all of your answers be out loud or verbal. Is that okay?

A Sure.

Q Great. Our normal tendency in conversation is to use, you know, head gestures or hand gestures. But none of that will show up on the transcript and that's why we ask for verbal responses.

It's also important for the sake of the transcript that we only speak one at a time. So I will do my best to wait until you're done talking before I ask my next question. And I would just ask that you also wait until I'm done before answering. Is that okay?

A Fine.

And where is the sound input so I know where to look.

Q Well, you have two. The phone, I think, will pick it up and from any direction. And our court reporter, are you using audio today as well?

COURT REPORTER: Just me.

BY MR. GANNAM:

Q Okay. So the best thing to do is just respond to me and if our court reporter has any trouble picking you up, she'll let us know.

If I ask any question that you do not understand, just please let me know what's wrong with the question and I'll address it. But if I ask a question and you answer it, I will assume that you both

heard me and understood me. Is that okay?

A Sure.

Q We will try to be respectful of everyone's time and get you out of here in time for your flight. However, this is not an endurance contest. And if you need to take a break, that's certainly appropriate. Just let me know.

I would ask that if there is a question pending, that you answer the question before asking for a break. Is that okay?

A Fine.

Q All right. Currently, are you under any medical condition or disability that would affect your capacity to testify truthfully today?

A No.

Q Are you currently taking any medication that could affect your capacity to testify today?

A No.

Q And if this case should go to trial sometime next year, are you aware of any situation or condition that would prevent you from being able to testify at trial?

A No.

Q Okay. Great.

Any questions for me before we go further?

A No.
Q All right. Please state your name for the record.
A Norman Spack.
Q And Dr. Spack, your address?
A 474 Revere, R-e-v-e-r-e, Beach Boulevard, Apartment 1003, Revere, Mass, 02151.
Q All right. Are you currently employed?
A No.
Q All right. Do you -- are you retired?
A Yes.
Q Okay. As of when?
A Two years ago.
Q What was your last employment position?
A I was a senior pediatric endocrinologist and founding -- founder and director of the Gender Management Service for the endocrine division at --
Q Go ahead.
A -- Boston Children's Hospital.
Q Okay. And that employment ended about two years ago when you retired?
A Yeah.
Q And since you retired, have you done any kind of consulting or other work for pay or remuneration of any kind?

A Not directly from Children's Hospital. But I voluntarily go in to consult on problematic cases.

Q And are you compensated for that?

A No.

Q All right. So have you done any kind of compensated work since your retirement two years ago?

A A fair bit.

Q Okay. What kind of work?

A It's all visiting professorships at pediatric medical centers.

Q Do you currently hold any professorships?

A My professorship will never -- it stays with me until I die. So I'm an associate clinical professor of pediatrics at Harvard Medical School.

Q Anywhere else? Other institutions?

A No.

Q What was the last course you taught?

A The last course I taught was a major seminar to the second-year Harvard medical students on gender dysphoria in a young adolescent.

Q And when was that?

A That would have been about March -- they're usually in March -- 2017.

Q Was that before or after your retirement?

A It was really just about as I was -- the

academic year ends on July 30th, so by July 30th that year, I was retired.

Q Any other compensated work besides that March 2017 seminar -- or I should say since that March 2017 seminar?

A Well, if you consider the visiting professorships.

Q Okay.

A They're all compensated. And I've probably done about -- since I retired, probably done around five.

Q Can you just kind of tell me what that consists of? You said you've done five.

A I can tell you a good one from proximity. Last year, I did a two-day professorship right at All Saints (sic) Children's Hospital in St. Petersburg.

That would usually -- it always consists of a meeting the night before over dinner with members of the pediatric endocrine department followed by giving a major lecture on the subject of transgenderism in children and adolescents; and following that, a more informal case discussion, cases brought up by the residents and interns that follows the major talk.

Q So the five visiting professorships you've engaged in since you retired typically follow that

similar pattern?

A I would say so.

Q Okay. All right. Anything else then besides the visiting professorship, as far as compensated work that you've performed?

A No. I would say no because other work that I've done related to the field is co-authoring articles for publication and major journals. And there was one non-compensated work, with probably a fairly big legacy. I was able to win a $6 million grant from the National Institute of Health for a four-institution collaborative study of -- longitudinal study of transgender youth. And that was a -- it included ourselves, the Children's Hospital in Chicago, the Children's Hospital Los Angeles, and the Children's Hospital at University of California San Francisco.

And it was just beginning to take off and enroll patients as I was retiring.

And none of us were -- of all the people involved, the only ones who were likely to be partly subsidized in their work were the research psychologists and some of the other number-crunching researchers.

Q So would it be fair to summarize your involvement in that project as participating in obtaining the grant, but not doing the work the grant is

funding?

A That's exactly right.

Q And what is the subject -- or more specific subject of that longitudinal study for which that grant was given?

A The patients who were enrolled in that study were similar to the patients in age and qualitative issues related to the gender identity as the patients that the Dutch had used ten years before.

So the idea was to see if we had comparable results to their -- I should have to say, phenomenal results over the 22 years of age that they have followed their patients.

Q And generally speaking, what were the results of the Dutch study that you were trying to analyze or match or compare to?

A They studied 55 males and 55 genetic females who were living in the opposite gender. They were subjected to pubertal suppression and cross-gender hormones at approximately age 15, any surgeries were obtained -- that were done by age 18. They had been tested psychologically at the beginning of the study with specific attention to gender identity.

They were studied, again, at the midpoint when they were about to get the hormones of the opposite sex.

They were studied again before they would be considered eligible for surgery.

But the critical thing that was done that was published was they were studied at age 22 to 24, so four to six years after the last formal treatment. Obviously they were continuing on hormonal treatment.

The stunning result that they showed -- and Holland is a different place from us. They showed that -- and it was published in The Journal of Pediatrics by de Vries, d-e, capital V, as in Victor, r-i-e-s. De Vries, et al. They showed that at the end of the game, the Dutch patients not only were psychosocially normal but their results were better than a cohort of age-match controlled patients.

Q So that's the Dutch study?

A Right.

Q And did you complete the longitudinal study -- or was the longitudinal study for which the six million NIH grant was given completed?

A Hardly.

Q Okay. Tell me about the process of that study.

A Well, it meant that every -- the goal was for every one of the four centers to enroll a hundred patients.

Q Okay.

A Okay? And to enroll them over the course of a year, maybe take two years to enroll them, and then follow them for -- it would probably be -- they'd start at the very beginning of puberty, and then -- so it would be a six- to eight-year follow-up.

When the NIH does this, they do it with the understanding -- and this is a great benefit to the researchers -- that you can keep the patients who fund you to do so.

Q So the -- from the inception of the study funded by the NIH grant to its completion, how long a period of time are we talking?

A Well, to do -- it could really be -- to get to the same point that the Dutch were at -- remember, they were at two to four years post 18. So they were 20 to 22. And our patients, to get to that point, would have to be almost ten years from eight to 12.

You understand that a person who is biologically female is more in a pubertal status of starting on average between age ten to 12, whereas natal or genetic males are more likely to be 12 to 14.

Q So that particular study that the $6 million NIH grant went to, we're years away from completing that?

A Right. And that amount of money is being divided over four institutions.

Q Okay. Very good.

All right. So apart from that -- the visiting professorships you identified, your participation on the project that won the $6 million NIH grant, what other work have you done, even without compensation, since your retirement two years ago?

A Since I trained my -- since I trained many of the people around the country who serve as directors of programs like ours, I get a lot of phone calls. And I also get questions based on my experience from my successors at Children's Hospital.

Q And have you done any other writing besides the -- for example, the grant application?

A Yes. But nowadays, I do it selectively. So I let my -- I let my trainees take the first officership and I take the editing.

It suits their careers to be first office.

Q Has anything been published that you are author of or co-author of since you retired?

A Yes. There was just one review article on the treatment of transgender youth. And that was by Shumer, S-h-u-m-e-r, and I.

Q Do you know what publication that appeared in?

A I forgot.
Q And do you know the year or month and year?
A I believe that was published in this year.
Q In 2019?
A Yeah. Earlier in the year.
Q Okay. Do you currently do any work for any non-profit or charitable organizations, either in a formal relationship or in an informal relationship?
A Yes.
Q Tell me about that.
A In a sense, it's actually how I got my start seeing the very first transgender patients that I ever saw.

When I was training in adolescent medicines from 1974, and then through my faculty status for at least a decade, I used to -- I used to work for a marvelous organization run by a wonderful nun named -- the organization is still thriving. It's called Bridge Over Troubled Waters. And they ran a very elaborate van set up to actually have a full medical treatment room. And we would go travel around the city of Boston, not far from where you were eating because the Boston Common was one place we went.

We went to Harvard Square. And we sometimes went to what they call the Combat Zone.

But this is a organization that -- the van was a place to look at things medically. But in point of fact, the major function of the van was to be a source of information to the street kids.

The organization recognized that if they -- if a kid came off the -- a bus, came off the train, or whatever, and was looking for a place to stay, had no home or whatever, running away from home, we had X number of hours to latch on to that kid and be sure they don't fall in more evil hands.

And so I've been on the board of the organization. They run a homeless shelter. They run a program for single mothers. They recognize -- this is interesting -- they recognized that a lot of kids wouldn't go for jobs because they were too embarrassed by their teeth or lack thereof. And they set up an entire dental clinic from Tufts dental school.

And they were doing every kind of dentistry.

Q Are you still on that board of that organization?

A No. I dropped off the board, but I maintain my contacts.

Q Do you volunteer for them or still provide any assistance to them?

A I provide medical advice to them, on the

larger picture.

Q And did this organization cater to or specialize in services to children who identified as LGBT or was this open to all kids that it encountered on the street?

A It was open to any kid who was on the streets. But I discovered, from talking to the people who do the demographics, that there was an overrepresentation of LGBT kids. And they were, as they told me, not run-aways, but they were throw-aways.

Q Meaning?

A That they were thrown out of their home because of the sexual orientation.

Q Any other organizations that you currently do work -- or that you currently work with besides Bridge Over Troubled Waters?

A There's an organization -- actually interesting, it's called Keshet, which is Hebrew for rainbow.

Q How do you spell Kesher?

A Keshet is K-e-s-h-e-t.

Q Oh, Keshet.

A And it's interesting that the Jewish federation in Boston has a division devoted specifically for kids who are, in the rainbow sense, LGBT. And I

advise them. I do a lot of local speaking gratis for schools and religious organizations.

Q Do you do any work either formally or informally for the NCLR or National Center for Lesbian Rights?

A No.

Q Have you ever?

A No. I have done -- in fact, I will soon, in a couple months, do the second major talk for Parents and Friends of Gays and Lesbians, which is a national organization. And I'll be doing a plenary address for them in September in Asheville.

Q In Asheville?

A Yes.

Q And have you spoken for that organization before?

A A long time ago.

Q Okay.

What about, have you ever done any work with or for an organization called Equality Florida?

A No.

Q What about The Trevor Project?

A No.

Q And Southern Poverty Law Center?

A No.

Q Have you ever testified as an expert witness before, either in written testimony or declaration or in a deposition or a trial or hearing?

A Yes.

Q How many times before?

A I think there was -- one particular case comes to mind. An it was not in the realm of LGBT.

Q Okay. And when was that case?

A I would say that it was probably 1970s. And I remember it vividly.

Q Where was it geographically?

A It was in Boston at the Boston family court. And it was a case of a care and protection for a 12-year-old diabetic young man who family neglect was causing him to be repeatedly admitted.

Q And since then, have you done any kind of expert testimony in court?

A No.

Q All right. I want to talk about your engagement as an expert in this case. How did that come about?

A I'm trying to think of who contacted me first. I think -- correct me if I'm wrong, but I think it probably came from this office.

Q Well, just testify to the best of your memory.

A Yeah.

Q Unfortunately, Mr. Williams can't help you answer.

A Yeah. I think it was through this office. I'm not necessarily known in these parts. And we don't have a center in these parts.

It's possible that I was recommended by the head of endocrinology at All Saints (sic) Children's in St. Petersburg because we happen to be very good friends and he's very senior.

Q So at some point in time, you communicated with someone here at this law firm?

A Right.

Q The Burr Forman law firm?

A Right.

Q Okay. Who was the first person you spoke with at this firm?

A I believe it was Rob Williams.

Q Mr. Williams that's sitting next to you there?

A Yes. I think, I'm virtually certain. Although it's also possible that Shannon had communicated with me about the situation. Not a specific case. And it's possible that my answer to Shannon was that I would be willing to be involved.

Q And by Shannon, you mean Shannon Minter, the

attorney for NCLR?

A Yes.

Q Who's also in the room with us today?

A Yes.

Q How did you know Shannon before, if you did?

A Well, I didn't know Shannon before, but I have subsequently found out that Shannon is very well known to attorneys in Boston -- do you know the organization GLAAD?

Q I'm familiar with it.

A Yes. So the head of transgender services for GLAAD is somebody I have had a close relationship to and have advised and even -- well, I gave verbal testimony. Not in a court. It was actually in a -- it was actually a joint committee of the main legislature.

Q So is it possible that the first person you spoke with about possibly being an expert in this case was Shannon?

A I'm not sure it would have been spoken. It would have been an email.

Q Okay. So is it possible the first communication regarding your work in this case could have been an email with Shannon?

A Right.

Q Okay. And when was that?

A This is just a ballpark. I would say somewhere around four months ago, maybe.

Q And do you still have any email communications that you had with Shannon regarding the engagement?

A I believe I do. Not specifically about the engagement but about -- I recall receiving a fascinating email from one of my former trainees. And it had to do with new findings in transgender children, something you should know about. He said, this is hot off the press. And I took Shannon's -- the email came to me and it had a gigantic website. And I forwarded it to Shannon.

Q What email address do you use to communicate with Shannon? Or did you use to communicate with Shannon?

A I can't remember it. But it was, I believe, the name Shannon was in the email.

Q Sorry. Not Shannon. Your email address --

A Oh.

Q -- that would get to you. Sorry.

A Okay. So I have a typical Children's Hospital address. It's Norman.Spack@childrens.Harvard.edu.

Q Is that your primary email address?

A Yes.

Q And even though you retired, would that be a permanent email address that you're allowed to keep?

A You're allowed to.
Q Do you communicate with any other email accounts?
A No.
Q Okay. All right. As far as -- you said it was about four months ago when you were engaged. What were you asked to do in this case?
A Well, I'm not entirely sure that Shannon was the one to be -- to tell me what was required.
Q Okay. Thank you for clarifying that.
A It's quite possible that Shannon said they had a case that was a municipal case. And I think that referred me to Rob. And I think it was Rob who gave me a more full picture of what's come out.
Q And did Rob communicate that to you in writing, through an email, or some kind of document?
A No. I think it was on the telephone.
Q Okay. And so going back to that assignment or that request of you, what were you asked to do in connection with this case?
A Well, it was looking for -- he was looking for an expert witness in an area that involved treatment of youth, and particularly adolescents. I guess my -- it's possible that my CV is online, but one thing -- there are two things that would make me an appropriate person,

and that is -- there are very few people who have -- that were boarded in adolescent medicine and endocrinology.

Q By "boarded," you mean board certified?

A Board certified. Yep.

So it seemed that I would be an appropriate person. And on top of that, I had seen about 250 adolescents. But early in the game, I volunteered to take care of adults. And I saw about an equal number of adults.

Q So understanding, generally speaking, you were asked to be an expert witness. Was there a specific task or specific tasks you were asked to perform in connection with the engagement?

A You know, I think it was still somewhat vague. I think it was -- there were some issues -- there were some issues about who should take care of these patients. And I think I was asked for the approximate date in which these things would come together. And that was more important to me than anything.

And then it was probable that in a subsequent conversation it was clear that the issues had to do with what we used to call reparative therapy or conversion therapy.

Q So understanding that the initial conversation

or conversations may have been somewhat general, at some point, did a specific, you know, list of items or requests materialize so that you could, you know, then proceed as the expert?

A Well, I think that -- actually, all I had to hear was that it was an issue of reparative or therapy. Anything that related to aversive or reparative therapy, I would be interested in.

Q Let me back up a minute. When you testified before the main legislature --

A Yeah.

Q -- or maybe you said a committee of the legislature. Let me stop there. Was it a committee of the main legislature?

A It was a committee of both sides. So it was a joint committee of the Senate and legislature.

Q So both houses?

A Both houses were represented. But I would say that the total number of sitting in that big horse shoe must have been about 15 people.

Q What was the subject matter of your testimony there?

A The subject matter of the testimony, it was a question of bathroom use in a 12-year-old genetic male, but an affirmed female, and an identical twin too, who

had been always accepted as a female at school, allowed to use the ladies room, et cetera. And things changed when the child who transferred into the school had a grandfather -- told the grandfather the story and the grandfather started spying on the school.

Anyhow, they changed -- they gave this girl a monitor to see that she wouldn't use the ladies room; only use the nurse's room. I'll just get to the end, in that the head of GLAAD was testifying. I was, the father was.

Ultimately, the girl said we did as good a job as we could have, but we failed. And the only one who could actually win the case would be her.

Q So what specifically were you testifying about before this committee?

A We were testifying that it was appropriate for her to use the bathroom.

Q I see.

A And they won the case.

Q So let me now -- have you testified before any other legislatures on GLBT (sic) issues?

A Only once. And it was before this. There was a bill before the Massachusetts legislature on the rights of GLBT people (sic), and antidiscrimination law, particularly with respect to housing, employment, and a

number of other things. It sat in committee for a long time. And then it ultimately passed. I was one of the panel that spoke to a joint committee of house and senate.

Q In favor of passage of the law?

A In favor of passage, yeah.

Q And have you ever testified before any legislative body, either state, municipal, county, regarding a therapy ban similar to Tampa's that we're here about today?

A No.

Q And earlier, when you said -- you used the term "reparative therapy." Can you tell me what that means to you when you use that word?

A To me, it means the same as trying to get the patient to return to living in their birth sex.

Q And you also used the word "aversive" a moment ago. What does that mean?

A Aversive means where the therapist actually slaps the patient's hand. It actually implies something noxious. Even at some point, these patients, years ago, was subjected to electric convulsive shock. So I would define aversive as a painful and noxious treatment.

Q And you, just now when you talk about reparative therapy and aversive treatments, are you

speaking specifically in the context of children or persons who identify as transgender or identify as a gender other than their birth sex?

A Not really.

Q Okay.

A I mean, that's my interest.

Q Okay.

A And I don't claim to have this -- sure, I have experience with gay and lesbian kids.

But I also know that these therapies have been applied to the gay and lesbian kids as well.

Q Do you considered aversive therapies to be unethical?

A Yes.

Q In all context or specifically in the context of what you define as reparative therapy?

A I can't think of anything that we could call therapy that would be associated with painful -- painful treatment.

Q In what states are you licensed as a physician?

A Massachusetts.

Q Any others?

A No.

Q And in the state of Massachusetts, is there a

board or authority, governmental board or authority that controls your licensure?

A Yes.

Q What is that board?

A Massachusetts board of medicine.

Q Do you know the makeup of that board in terms of the credentials or qualifications of the board members?

A To be on the board? I don't. But I'm pretty certain that some members of the board are not themselves physicians.

Q Is it your understanding that some or most of the members would be physicians?

A I would think so.

Q Does that same board hear any complaints about you or any other physician in the state of Massachusetts for unethical practices?

A Yeah. That's -- it's my understanding that they are the first to receive such complaints.

Q And would it be your understanding that if a complaint was made to that board about an aversive treatment by a patient, that they would investigate that and take that seriously?

A They would, especially because -- and I just found this out. I would have -- that Massachusetts

would have been on the forefront of this. But I just found out that prior to this year, in New England, all the states except Massachusetts and Maine had ordinances against reparative therapy or aversive therapy. But this year, both Maine and Massachusetts have joined the other four.

Q Okay. Prior to Massachusetts enacting some kind of statewide ban against reparative therapy, would it have been possible to submit a complaint to the Massachusetts board of medicine regarding unethical practices by a physician?

A I would imagine so, and then they would have had to run a case-any-case basis to decide.

Q Getting back to your engagement in this case, at some point were you given a specific list of tasks or instructions for what was needed from you as an expert witness?

A Yes. I have a notebook that's the size of Robert Mueller's that contains numerous other people's depositions and other comments.

Q Was all that material provided to you?

A Yes.

Q By Mr. Williams' firm?

A Yes.

Q Okay. Does it include a specific list of

things for you to complete or services to provide?

A No. The only thing -- and it was quite helpful because I had brought down from Boston, a huge amount was directing what areas I would likely need to focus on.

Q And that directive, was that regarding specifically your deposition today or the assignment in general?

A No. I think my deposition today.

Q I see.

A And, yeah.

Q Now, so far in this case, you have provided a declaration. Do you recall that?

A Correct.

Q And you're testifying here today. Are there other tasks yet to be completed in connection with your engagement?

A I don't think so.

Q So --

A There's one area that I think you should know --

Q Okay. What's that?

A -- because I think it will help you. And that is the issue of other physicians who have been associated with, you might call reparative therapy.

Are you aware of other physicians in Canada?

Q What do you want me to know about physicians in Canada?

A Probably the most famous physician who has been responsible for recommending a kind of coercive therapy, i.e., telling parents to -- that if -- to limit the child's toys and clothes, et cetera, to one room in the house and not permit the child to take any of those things outside the house. In a way, I call this a kind of coercive therapy.

And he's been head of the -- of the program at the hospital of sick children -- adjacent to the hospital of sick children in Toronto. And he has -- I just blocked on his name. I just blocked on his name.

Q You might remember it on a break or something later. That's fine. Just...

MR. WILLIAMS: I can't help you, unfortunately, under the rules, so...

THE WITNESS: It's blocked.

I've known him for 30 years. There are some things he's done that have been commendable with treating adolescents. But in treating children, I've had several patients go to see him and come back very depressed, very -- the child more dug in than ever.

BY MR. GANNAM:

Q What condition are we talking about?

A We're talking about gender dysphoria --

Q Okay.

A -- in a child who is prepubertal, perhaps 11 -- ten- or 11-year-old genetic male, affirming a female identity and having two other -- two brothers who initially were trying to do everything possible to get this child to act in a masculine way like they.

But they came -- the family came back from -- Ken Zucker is his name. And the brothers went to the parents and saw -- they said, he's totally depressed, he's lying on the couch, he won't do anything. And the parents were about to do what Zucker had recommended which was to give the child a birthday present, a boy-type toy. And the brothers suddenly changed their mind. They said, You can't do this, you've got to give her a girl thing. She'll just dissolve.

And then they went forward and treated her like a girl, dressed as a girl. Her progress has been phenomenal. And what happened was Zucker -- I think what actually happened was there are so many parent groups now of kids who have gender issues. They talk to each other. And I believe it was the parents that initially caused a review of his practices. And he

actually lost his position.

Q Did you participate in any formal review of Dr. Zucker's practices?

A No.

Q Do you know why he lost his position, apart from what you've heard from others?

A I have. It's interesting because I have a bill of particulars of what they -- what the reviewing committee in all of Canada had. And it seemed that it doesn't come to the conclusion of what should be done with him, but it does indicate in what ways he needs to improve the main standards.

And it appeared that one of the most problematic area was that he seemed to be operating in a vacuum, that he didn't bring in enough other specialists like social workers and et cetera. And it was quite secretive what he was doing.

Now, it's important I tell you this because I've been present at meetings where he speaks. And it's -- there's no -- he doesn't put any criticism or typical debate.

And he is often -- if the you read the DSM5, that Diagnosis and statistical manual of psychiatric diseases, or the APA, American Psychological Association standard of care, or the WPATH, the world professional

association of transgender care, it's very likely that what has been written as a standard of care of transgender youth was written by him. And so you better be sure you're reading the most up-to-date thing because a lot of the things that he wrote have been erased. And then nobody had the courage to say, we can't have his -- because he was basically codifying his approach.

Little kids don't necessarily know who they are, so let's not allow them to live in a way they want to. The worst case scenario that maybe they'll turn out gay and that's better than turning out trans.

That's how he would speak.

Q Did the City of Tampa rely on any of Dr. Zucker's work in connection with passing its ordinance?

A I think not.

Q Do you know?

A I don't know.

Q Getting back to your engagement in this case, let's start with your declaration, though. What were you asked to address in your declaration?

A I was asked to address my opinion about a therapy that convinces -- attempts to convince children and adolescents to remain in or return to the sex and behavior of the sex at birth.

Q And so apart from offering an opinion about that, what else or other specific items were you asked to address in your declaration?

A I don't actually recall that I had -- that there was another task.

Q And is --

A And, in fact, I don't think there was any mention in that for gay and lesbian youth.

Q Do you mean that your opinions are limited to children who identify as transgender or gender --

A Correct.

Q And a note about terminology. I see transgender and the abbreviation TGNC for transgender, gender nonconforming.

If I say TGNC, will you understand what I'm talking about?

A No.

Q So that's not an abbreviation you use?

A You know, all of these things can -- everybody has -- I'll give you an example. You might find some literature, even the literature that I helped write the standard of care from the endocrine society says standard of care for treatment of transsexual. Now, I wouldn't write "transsexual" because that's the European term, the broad-brush term for people who feel they're

in the wrong body.

I remember when transgender meant you felt you were in the wrong body. But you didn't qualify as transsexual unless you had surgery. So I find transgender to be sufficiently inclusive.

Q And will you just define what you mean by the word "transgender," then so, that we communicate clearly the rest of the day?

A Somebody who believes that their physical body does not conform to this sense of self.

Q And under that definition you just gave me, is that an absolute? Or are there degrees of those feelings of not -- of physical body not being congruent with how the person identifies themselves?

A That's a good question.

MR. MIHET: They're all good questions.

MR. GANNAM: Stipulate.

THE WITNESS: The point is, by the time they get to me, I tend to see only those who are pretty hardened in their feelings. But I'm not with them all the way.

Now, the one group that is not all the way who I have seen, the very frustrating group, that's the group that calls themselves gender queer, and I call them gender fluid.

But either way, they don't want to see me. It's the parents that want them to see me because there is no medicinal treatment for them unless they decide one way or the other.

BY MR. GANNAM:

Q So can you tell me or maybe give me a definition of the condition of a person who identifies as gender queer or what you call gender fluid?

A It's a person who doesn't commit to being either male or female. But that may take different -- manifest, for example, it could be someone who just sees themselves somewhere in the spectrum and it changes from day-to-day, and someone who sees themselves very much male one day and very much female the next.

Q Now, is gender queer or gender fluid itself a gender identity?

A It is, but it is as a term.

Q What does that mean?

A Well, because it gives you -- if you describe -- otherwise you'd have a great difficulty describing this person.

But if I say to you, this kid is gender fluid, then you wouldn't have expectations of is the kid going to strike you as a male or female.

Q So suppose we were to categorize the different

gender identities that at least are recognized in medicine in your field, would it be accurate to say there is male, there is female, and an in-between gender fluid captures everything in between or does it only capture some in between?

A No. If it's ill defined and especially moving, a moving target, I would call it a form of gender identity.

Q Okay.

A The thing I don't know, and I wouldn't be able to tell you -- I don't know if I'll live long enough to find out -- is how do these people end up? Are they on a path towards one or the other or not?

Q Now, you said earlier that when a minor would identify as gender fluid or gender queer presents to you, there's not a medical treatment for them. Can you just explain what you mean by that?

A Well, if they were certain they were to affirm a male identity, then they would need to be testosterone treated, unless they're making it by themselves.

If they affirm a female identity, they would need to be estrogen treated, unless they already are making estrogen themselves.

So many of the gender fluid kids take no medications.

Q Thank you.

Now, getting back to your declaration that you prepared in this case, just so I'm clear, was there ever a document or set of instructions provided to you by Mr. Williams' firm that said, for example, make sure you address these five points or this one point in your declaration?

A I think the -- I think that is the case.

Q Okay.

A Because I really didn't know what was going to transpire here.

Q And was that an email or some other kind of document?

A It may have been an email. I think it probably -- I mean, it would be too complicated for them to telephone it.

Q Certainly you needed something to tell you what --

A A template.

Q -- you were writing; correct?

A Right.

Q And as you sit here, do you believe that your declaration addressed what you were asked to write about?

A Yes.

Q Was there anything you were asked to write about that you declined to write about for one reason or another?

A No. But in fact, my first draft was really far too wordy. And what it really was was a kind of autobiography of my life and the terms...

Q Is that the word Rob used, "too wordy"? I'm kidding.

Did anyone review earlier drafts of your declaration besides this law firm?

A No.

Q Did you provide earlier drafts of your declaration to anyone outside of this law firm?

A No.

Q Did you receive input regarding what should be in your declaration from anyone besides this law firm?

A No.

MR. WILLIAMS: Off the record.

(Off the stenographic record.)

BY MR. GANNAM:

Q So, back to your engagement here. Apart from preparing the declaration and testifying here today, has your engagement involved any other work on your part?

A Only reading Tommy Hart's --

Q Let me ask you this, what did you do to

prepare for today specifically? In other words, your declaration was written and submitted. At some point, did you start preparing for your testimony today?

A Okay. I'll make this brief. And this was just yesterday, so this was a last-minute. I read the ordinance.

Q The Tampa ordinance?

A Yes.

Q Okay.

A I read my declaration. I read -- I read Dr. Hudson's narrative. And I read -- because I thought it was very well written, Dr. -- is it Glassman?

Q Glassgold, maybe?

MR. WILLIAMS: Glassgold.

THE WITNESS: Glassgold.

BY MR. GANNAM:

Q Anything else that you read?

A No.

Q And you said that this was yesterday that this occurred?

A Yep.

Q And did you meet with anyone to prepare for your testimony today?

A Yes. You gave us some extra time. But really, yesterday, we spent time. But that was not so

much a personal review. It was more related to the ordinance. And I think that was really it. That is -- yeah.

Q Who did you meet with yesterday?

A It's also possible that yesterday we read the -- Kenneth Zucker, the -- the Kenneth Zucker review, critical review.

Q And who did you meet with yesterday?

A With Rob, Shannon.

Q Anyone else?

A I don't think so.

Q How long did you meet for?

A I would say maybe three or four hours. After we went through the golf stories.

Q Did you have any other in-person meetings besides that meeting yesterday to prepare for your deposition today?

A No.

Q Okay. So we covered documents you reviewed and who you met with. All right.

Are you being compensated for your engagement as an expert witness in this case?

A I hope so.

Q What is your understanding of the arrangement?

A I understand that my expenses will be covered

coming down here, hotel, and that I would be compensated at what has been referred to as a municipal rate.

Q That makes me think lower than what you'd get anywhere else. Does that sound about right?

A It is.

Q So you testified -- compensated for time spent doing what, exactly?

A Preparation, attendance at meeting -- the meeting unrelated to this one, and this deposition meeting.

Q And what is the rate that you're being compensated at? Do you know what that is?

A I think I know what it is. The non -- the deposition rate I believe is $250 an hour. And the non-deposition work is half that.

Q Are you offered any enhancement or additional compensation based on the outcome of the case?

A No.

Q And to your understanding, who is paying your compensation?

A I assume this law firm is.

Q Do you have any written agreement to that effect?

A No.

Q All right. Let's do this. Should we take

a -- let me just get something on the record first, make the best use of our time here. I'm handing you a document that I'm marking as Exhibit 36, which for the record is just a continuation of the numbering of plaintiffs' exhibits.

(Exhibit 36 was marked.)

BY MR. GANNAM:

Q Doctor, what I've handed you is titled "Declaration of Norman Spack, MD," with a case style at the top reading United States District Court for the Middle District of Florida, Tampa Division, Robert L. Vazzo, LMFT, versus City of Tampa, Case No. 8:17-cv-02896, et cetera. Do you recognize this document?

A Yes.

Q Is this the declaration that you prepared for the City of Tampa as an expert witness in this case?

A Yes.

Q You had an opportunity to review this yesterday; correct?

A Yes.

Q Is there -- is everything in this declaration still accurate and truthful as we sit here today?

A There's one slight error.

Q Okay. Please point that out.

A On my part. Number nine, I've treated more than 250 transgender children, not 140.

Q You're talking about number nine on Roman numeral one on page two?

A Yes. The very last line.

Q Okay. And that number that reads now says, "I've treated more than 140 transgender children and adolescents." What should the number be?

A 250.

Q Okay. Do you know why you said 140 before?

A I don't know. I was -- I think my mind had wandered to how many people the study had enrolled.

Q Other than that change, are there any other changes necessary to make the entire declaration accurate?

A Okay.

Q Is that --

A My CV.

Q I'm not sure if my question and your answer matched up. So let me ask, just for the record. Are there any other changes that need to be made to the declaration to make it entirely accurate?

A I think not.

Q Did anyone assist you in writing the declaration, besides any assistance this law firm may

have provided in formatting and things like that?

A No.

Q So is it fair to say all the content of the written part came from you?

A Yes.

Q About how much time would you say it took you to write the declaration?

A Well, I talked with them after initial. So there was an initial, and then...

I would say that total together, I would say it would probably have been about three hours.

Q Have you done any additional research or writing in connection with this expert engagement since you submitted this declaration?

A No.

Q Do you intend to give any opinions in this case that are not reflected in this declaration?

A No.

MR. MIHET: Good.

Just kidding.

BY MR. GANNAM:

Q And I didn't -- it's probably just a formality, but will you turn to page four of the declaration? The signature appears as Norman Spack. Is that your signature?

A No. I can't write that well.
Q Is that an electronic signature made on your behalf or that you effected yourself?
A No. I believe it's electronic, and it was with my approval.
Q Okay. Very good.
All right. Why don't we take a break now, maybe just a five-minute comfort break, and try to -- are you okay with taking a little bit later lunch today, just so we can cover some --
MR. WILLIAMS: I'm okay, as long as Dr. Spack is.
THE WITNESS: I'm okay.
MR. GANNAM: All right. We'll make this very quick, if that's all right with you. And then we'll come back and get some more testimony.
(A brief recess is had from 12:17 p.m. to 12:44 p.m.)
BY MR. GANNAM:
Q Dr. Spack, will you take a look again at your declaration that we marked as Exhibit 36. And on the first page, I just want to look at numbered paragraph two. You see that?
A Yep.
Q And first sentence says [as read]: I have

read the ordinance number 2017-47, an ordinance of the City of Tampa, Florida, relating to conversion therapy on patients who are minors.

Did I read that correctly?

A Yep.

Q And is that the ordinance that we've discussed up to now in today's deposition?

A Yes.

Q And you go on to say, the next sentence -- I'm sorry. The continuation of the same sentence. You read [as read]: And in my opinion, the ordinance is based upon the evidence-based medical consensus regarding appropriate treatment of transgender and gender-nonconforming youth and the ordinance is necessary to effectuate the City of Tampa's interest in protecting vulnerable minors from the serious harms caused by conversion therapy.

Did I read that correctly?

A Yep.

Q So just want to be clear for the record. Your opinion is offered only in connection with transgender and gender-nonconforming youth and excludes considerations specifically relating to gay and lesbian and bisexual youth. Would that be fair to say?

A That was my understanding.

Q Okay. Very good.

And when you use the term "conversion therapy" in that sentence, what does that mean?

A Some people would call it -- I'm trying to think -- different names for this. But in any case, conversion therapy is a therapeutic approach to try to induce and encourage patients who are minors, in this case, to maintain or revert to their biologic sex, or probably better to say a gender identity consistent with the biologic sex.

Q And in that sense, would that -- is that the same definition, essentially, that you gave me earlier for the term "reparative therapy"?

A Yes.

Q Okay. Now, in the middle of that sentence, appears the term "evidence-based medical consensus." Can you explain what that term means?

A Yes. That there are medical writings that -- I'm trying to see how it's written. Yeah. There are medical writings that state that the care of transgender and gender-nonconforming youth is best accomplished in methods consistent with the ordinance.

Q Now, you've had an opportunity to read the ordinance; correct?

A Yeah.

Q And is it your belief that what the ordinance prohibits is what you defined earlier as conversion therapy?

A I believe so.

Q And do you have any understanding or belief as to whether the ordinance prohibits more than what you identified as conversion therapy?

A It's possible that the ordinance deals with gay and lesbian youth. But it wasn't my purview.

Q Okay. Fair enough.

So specifically as it relates to transgender and gender-nonconforming youth, do you have any belief or understanding as to whether the ordinance prohibits something in addition to or beyond what you earlier defined as conversion therapy?

A I don't think so.

Q So this sentence where you said "the ordinance is based upon the evidence-based medical consensus regarding appropriate treatment of transgender and gender-nonconforming youth," that is to the extent the ordinance prohibits what you identified as conversion therapy. Would that be fair to say?

A That's fair.

Q Now, did you cite to any of the medical writings that you said this evidence-based medical

consensus is based on, in this declaration?

A I believe there are a couple of -- it's hard for me to remember which is in what reference. But if you look on page two, there are a number of references in which I was a co-author.

Q All right. Are you referring to the footnote denoted by the asterisk on page two?

A Yeah. Right.

Q Okay. And do all of the documents referenced there have in common that you are an author or at least co-author of the document?

A I see that I am.

Q Now, if I refer you to the numbered paragraph five on page two where the asterisk appears about halfway through the paragraph, following the sentence [as read]: I have published peer-reviewed articles on the treatment of transgender people with a particular emphasis on gender identity and youth.

Do you see that?

A Yep.

Q So does this footnote asterisk specifically relate to that sentence?

A They do.

Q Okay. Do these articles or documents identified in that footnote, are those intended to be

support for your statement in paragraph two that there is an evidence-based medical consensus regarding appropriate treatment of transgender and gender-nonconforming youth?

A Not all of these references.

Q Okay.

A But I believe that there is -- in at least one, there is reference because when we write, we often not only write about how to, but how not to.

Q When you say "when we write," what are you referring to?

A When any of my colleagues -- these are all people who are members of the Gender Management Service. And it's interesting that especially around the time that these were written, I just recall conversations about, don't you think we should put something in about what not to do. And to some extent, that was a dart pointed at Dr. Zucker.

Q So of the references identified in footnote asterisk, which of them would you offer as support for the statement in paragraph two that the Tampa ordinance is based upon evidence-based medical consensus regarding appropriate treatment of transgender and gender-nonconforming youth?

A You know -- all right. I'll give you an

example. The first one by Tishelman could well have it.

The second, by me, Clinical Crossroads.

Laura Edwards-Leeper and myself could have.

Q Now, when you say "could," does that mean they do support it or they might?

A No. I can't -- I can't recall which ones because it would likely be a sentence or something that, in fact, any of them could.

Q So, as you sit here right now, can you identify one of them that does?

A I can't be sure. They're several years old. But if anything, that makes it more likely to be included because this is when the gender clinic was -- this is reflecting our treatment in the gender clinic. And we were very likely to put something in that reflects -- reflects our feeling about reparative or conversion therapy.

Q So as I understand you, you're saying it might or may even likely these articles may include -- strike that question.

If I understand you correctly, you're saying these references in the footnote asterisk may address conversion and reparative therapy, but as you sit here right now, you're not sure?

A I'm not -- I'm pretty sure they include it.

I'm not sure which one.

Q And when you say -- do you have that same level of confidence specifically regarding the statement in paragraph two that the ordinance is based upon evidence-based medical consensus regarding appropriate treatment of transgender and gender-nonconforming youth?

A I'm sorry. Can you repeat that?

MR. GANNAM: Can you read back my question?

(The Court Reporter is directed to read back the previous question and/or answer.)

THE WITNESS: Yes.

BY MR. GANNAM:

Q Is there a reason why you didn't include a citation to authorities in paragraph two?

A I'm not sure that this -- I'm not sure that it's fair to say that it doesn't include it. It doesn't include that any particular case. But it takes into account our opinion based on evidence-based consensus, which means the articles would have some citation.

Q Let me ask you this, do you agree with me that paragraph two on the first page of your declaration itself does not cite to a medical authority either in the text or by footnote or some other reference?

A All right. I'm just...

MR. WILLIAMS: You're referring to paragraph

two on page one of his declaration?

MR. GANNAM: Right.

THE WITNESS: Well, I thought it would be -- I think this is pretty straightforward. It's one thing for me to say I have read. It's another thing to say I have published. And so the -- it makes a stronger statement when you asterisk something that leads to citations, all of which include my name. Number two doesn't -- would not be considered a medical citation.

BY MR. GANNAM:

Q Okay. So I think you answered perhaps why paragraph two doesn't include a reference. My question was actually that, do you agree with me that paragraph two does not contain a reference to other medical writings to support any of the propositions in that paragraph?

A Right. That is correct. However, when I did not write anything in paragraph two, I knew that there would be references coming in paragraph five.

And, in fact, in most medical journals, the references don't even come to the very end of the article. I thought this would be more relevant to have the references close on the same page as a relevant point.

Q And just so I'm clear. This declaration does not include any kind of end notes or list of references or bibliography or anything like that; correct?

A Right. Because otherwise, you wouldn't have footnotes.

Q Okay. So apart from this footnote asterisk that appears on page two referencing a sentence in paragraph five, are there any other lists of references provided in your declaration?

A No.

Q Numbered paragraph six on page two refers to a clinical practice guideline attached as Exhibit B.

Do you see that?

A Yes. Okay. There were three things, yeah.

Q And if I flip to Exhibit B of your declaration, which is approximately the last third, maybe, of the packet that's in front of you, do I see that guideline that you reference in paragraph six?

A Exhibit B?

MR. WILLIAMS: This one right here. Let me find it for you real quick.

BY MR. GANNAM:

Q Yeah. Rob can help you find it real quick. That's not a problem.

MR. WILLIAMS: Parenthetically, off the

record.

(Off the stenographic record.)

BY MR. GANNAM:

Q All right.

A Yes.

Q So in Exhibit B, we see that [as read]: Endocrine treatment of transsexual persons, an independent society clinical practice guideline.

Did I read that correctly?

A Yes.

Q And tell me your involvement in preparing this document in Exhibit B.

A As a member of the task force, I helped draft and review drafts. We had two full days of meeting in New York. And then the drafts were formulated. We sent our suggestions in. You may not have seen an evidence-based -- if you notice the -- first of all, if you notice where the people came from, this was international.

Also, take a look at the circles next to many of the statements. It's interesting because it shows how much we need to know.

Q Can you give me a page reference where I can see exactly where you're talking about?

A I think a good page for it is 3133. And look

down at 4.0.

Q All right.

A So there are up to -- up to four circles and have a cross inside. And the degree to which -- the degree to which the statement is borne -- meets the title of -- meets the status of evidence basis. Those get the highest number.

And there was a person who -- certainly if there's a -- two of them are crossed, and absolutely if there are three or four, that's strong evidence basis.

When you see, for example, under 2.0, we suggest deferring surgery until the individual is at least 18 years old. And that was only given one. And that's because we really aren't sure of what we should recommend.

Q Let me ask you, before getting into some of those details. You said that you participated in drafting these guidelines; correct?

A Right.

Q And you participated in the process of reviewing earlier drafts before this final guideline came out?

A Yes.

Q And as the -- as this guideline exists, or existed when it was published in its final form, were

you in agreement with everything in it?

A Yes.

Q And okay. And did you have an opportunity during the drafting process to address any points that you may not have agreed with or enter influence what was in the final version?

A Yes. That's a good question. There was -- God, it's been a while.

MR. WILLIAMS: Finally, you stumbled into a good question, Roger.

THE WITNESS: No. There was -- oh. I disagreed with them and I held back. In 2.0, down to 2.4, it says [as read]: We suggest that pubertal development of the desired opposite sex be initiated at about age 16.

I won by having the term "at about age 16," in part because I thought age 15 is often very appropriate.

So that's my great contribution, is to get "at about age 16". There may be another something like that.

BY MR. GANNAM:

Q All right. I can appreciate the distinction.

All right. So now let me ask you to look at page 3135. And there's a section on the right column

that reads [as read]: Method of development of evidence-based clinical practice guidelines.

Do you see that?

A 3135?

Q Yes.

A Yeah, okay.

Q And then about halfway down that column, maybe a little farther, there's a sentence that begins "in terms of the strength."

Do you see that?

A Yep.

Q All right. I'm going to read a portion for the record. [as read]: In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend," and the number one, and weak recommendations use the phrase "we suggest," and the number two. Cross-filled circles indicate the quality of the evidence such that one cross denotes a very low quality evidence, and that's a graphical one cross. Two crosses denotes low quality. Three crosses denotes moderate quality. And four crosses denotes high quality.

Have I read that correctly so far?

A Yep.

Q And then it continues [as read]: The task

force has confidence that persons who receive care according to the strong recommendations will derive, on average, more good than harm.

Did I read that correctly?

A Yep.

Q So does that sort of summarize what you explained earlier about the significance of the cross symbols and --

A Yes.

Q -- strength of the recommendations?

A Yes.

Q So for example now, turning back to on page 3133, for example, item 2.1.

Do you see that?

A Yep.

Q It says [as read]: We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development.

Did I read that correctly?

A Um-hum.

Q And it's assigned a one for strength of recommendation, and one cross for quality of evidence; correct?

A Right.

Q And so to interpret that, I would say that 2.1 has a strong recommendation based on very low quality evidence; correct?

A Right. And that's because no one had carried -- carried it through yet. You've got to look at the date of this.

Q And based on how that strong recommendation I just read on 3135, that that means the task force had confidence that persons who received care according to that recommendation will derive, on average, more good than harm; correct?

A Yep.

Q Now, that also means that there's a possibility of some subset of the people who received treatment, according to that recommendation, were experiencing some degree of harm; correct?

A It's hard for me to imagine -- are you talking about harm during the course of treatment?

Q Well, I'm referring to whatever the explanation is on page 3135 that I read earlier where it says [as read]: The task force has confidence that persons who receive care, according to the strong recommendations, will derive, on average, more good than harm.

A Right.

Q So what does "harm" mean in that sentence?
A I can give you one possible potential harm --
Q Okay.
A -- that we just didn't know the answer to, but were concerned about.
Q Okay.
A We were concerned about the fact that if you -- since most significant amount of your bone density is acquired in puberty, that to shut puberty down altogether might slow down bone density. And the potential harm would come later with perhaps more reasonably fractured or end up with meeting a fall causing a hip -- breaking a hip, et cetera.
Q So at the time these guidelines came out in 2009, is it accurate to say that the -- there was a perceived risk of harm of --
MR. WILLIAMS: Lunch is here.
BY MR. GANNAM:
Q -- the bone and density not developing because you --
A We stopped puberty.
Q -- you stopped puberty.
Would it also be fair to say you couldn't measure with a percentage, for example, how much more likely that was to happen as a result of stopping

puberty?

A No. And one of the reasons for that is that there was no way to be -- no one's ever done this before. So the issue was if they did have a slowing of bone density, would they show catch-up as soon as they started on estrogen?

Q And so when I asked, were you able to assign a percentage of the greater or increased likelihood of this bone density not developing as a result of the treatment, is your answer that, yes, you were able to quantify that, or no, you were not able to quantify that?

A We were able to -- there is a method of testing bone mineral density through a DEXA scanner.

And that was done all the time through this.

Q I'm not sure that's the question I asked. So there is a method to test bone density?

A Yes.

Q And that has assigned some numerical value?

A Yes.

Q Okay. My question is, At the commencement of treatment, according to recommendation 2.1, were you able to quantify the increased risk that the bone density would be hindered or stopped as a result of the treatment?

A We couldn't -- we couldn't predict.
Q Okay.
A We couldn't predict.
And I should say, it also fit into the question of when to start. Because if you started, let's take a girl, a genetic female, if you started her a little later on pubertal suppression, you might have achieved a higher bone density at the time you start. But there are other contravening issues with starting a girl late because the average girl we see is -- we want to see them at ten to 12, and they're coming in at 14, which means how much can you -- how much womanhood can you take away from them when they're already women.
Q So there's a balancing of considerations when you are setting out to stop or cease pubertal development through --
A Right.
Q -- a medical intervention; correct?
A Yes. And I'll tell you one other thing.
One of the reasons we felt comfortable for using -- and the Dutch felt comfortable of using this pubertal suppression is because there is a -- we all in endocrinology have dealt with usually girls, and usually without tumors who are in this situation of precocious puberty. That is puberty that starts at three, four,

five -- I mean, the whole nine yards. And it used to be an absolute mess because those girls end up looking five, seven years older than they are. And they menstruate at kindergarten. And because their growth plates close early, they end up very short.

Now, the drug we use for pubertal suppression has enabled them to go through a normal childhood. The drug is stopped at early puberty age. They go into normal menstrual cycles. They become pregnant when desired. They become mothers. It's one of the great success stories.

But to extrapolate what happens to their healthy bones, healthy because they had advancement in their maturation process, has always been the question of, yeah, but these girls we're starting are not advanced bone age, bone to start with.

Q Meaning the girls who had not experienced this precautious puberty, as you called it?

A Yep.

Q Didn't start on the puberty blocking regime?

A Right.

Q Didn't have that benefit of the extra bone development?

A Right. And nobody has ever done this before.

Q I see.

MR. WILLIAMS: All right. Lunch is here. You guys call the shot on that, since you're asking the questions.

MR. GANNAM: Let me just see.

(Off the stenographic record.)

BY MR. GANNAM:

Q Let me get back to page one of the guideline, or it's actually 3132 is the journal page number. At the summary of recommendations, 1.0, do you see that? We're still on Exhibit B. I'm sorry. I didn't mean for you to flip back to the...

The first page of the article itself. There you go.

Do you see the summary of recommendations at the bottom?

A Yep.

Q All right. Under diagnostic procedure, 1.1 [as read]: We recommend that the diagnosis of gender identity disorder, GID, be made by a mental health professional, MHP.

Did I read that correctly?

A Yep.

Q Now, I think you alluded to this earlier, but let me ask. Is it accurate to say that these guidelines apply to treatment that would occur after a child has

already had some contact with a licensed mental health provider and determined that there is gender identity disorder or gender dysphoria or a condition that could be helped by the treatment outlined in this guideline? Is that an accurate statement?

A I'm not sure. I mean, the issue is that the -- it could be the -- are you talking about there has to be two people involved?

Q Well, maybe you can just explain to me what that means.

A Because what I'm trying to say is that any, any mental health professional who is experienced in dealing with gender identity disorders needs to be the person who assesses whether the kid is the real deal.

Q Okay. And so just for clarification, then, you don't hold yourself out as a mental health professional, do you?

A No. I wouldn't -- I wouldn't claim -- I'd put my two cents in from talking to the kid. But I would make my -- our psychologists are the ones who do this testing and make the -- a true judgment about these kids.

But I don't -- it could be a social worker. It could be a psychiatrist. And somebody who's really invested in this as an endeavor.

Q So would it be fair to say you're an endocrinologist, generally speaking?

A Right. Yes.

Q And so the treatments that are outlined in this guideline --

A Right.

Q -- are treatments that, generally speaking, would be administered after someone in the mental health field first sees the child?

A Right. Yes.

Q Okay. But that's not something -- you don't make that initial determination. The mental health professional would make it; correct?

A Right.

Q And then one more statement. And then we can have some lunch. Also on that same page, 1.2 -- I'm sorry if you closed it up again.

A Okay.

Q 1.2 reads [as read]: Given the high rate of remission of GID, after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children with GID.

Did I read that correctly?

A Yes.

Q And that's a strong recommendation based on

two crosses or low evidence; correct?

A Right. I think this has just come out in a new form.

Q Okay. "This," meaning this guideline?

A This guideline. And I haven't seen it. I was not on the committee this time. I think that it's probably -- if you're looking for it, it's probably still under Hembree.

Q What's the year of the new guideline?

A I think it would probably be either this year or last year.

Q Let me just ask you this, then, with that clarification. The assumption, given the high rate of remission of GID after the onset of puberty, let me just stop right there. In 2019, is it still true that there's a high rate of remission of GID after the onset of puberty?

A I'm sorry. I want to be sure I...

Q I'm on page 3132, item 1.2, bottom right of the page. Do you see where it says, "given the --

A I do, yeah.

Q So if I just stop with that assumption here that given the high rate of remission of GID after the onset of puberty, is it still a case in 2019 as we sit here today, that there is a high rate of remission of

GID after the onset of puberty?

A The thing I'm having trouble with in the statement is that you can read that statement as, you know, after the onset of puberty, many of these kids won't be transgender anymore. Right? That's not how I read it, but I'm looking at the next section, do you...

Oh, okay. I get it. This is for untreated people.

Q Okay. Explain that. What do you mean by that?

A Okay. So this is a description of kids who may show cross-gender treatment, but that -- but unless they really meet the treatment -- they're looking at kids who have cross-gender behavior, but not so much as to qualify as being transgender.

Q I see.

A Okay? So they're saying -- it's saying, therefore, hold the fort with prepubertal kids.

Q So --

A Because --

Q Go ahead.

A Because that some kids will act in a prepubertal way, act in their birth sex later, but they're not really the same. And so what they're saying here is don't encourage that kid to do a complete social

transition as a prepubertal kid because that kid may not turn out. That's one of the -- one of the reasons for waiting until the beginning of puberty before making distinctions about how you present -- how your kid should present.

But this may have changed in the recommendations because some of the people who have been involved in the recommendations are stronger believers in letting a kid present themselves whatever way they want.

Q And by social transition, do you mean, for example, a biological boy, if he were to socially transition, that means fully identifying as a girl --

A Right.

Q -- as a gender identity; correct?

A Right.

Q Okay. And just so I read this correctly, in 1.2, we're talking about a group of children who have experienced some gender dysphoria or have been diagnosed as having gender identity disorder but have not identified as the other gender. Would that be a fair --

A Well, they haven't -- their degree of identification with the other gender is less.

Q And but just reading this here, their degree of identity with the other gender is less, but still

enough for them to have been diagnosed with gender identity disorder; correct?

A Right.

Q Okay. So --

A And if there's any reason why you have to have incredibly skillful psychologists and testing psychologists, it's over stuff like this.

Q Meaning, you have to have an incredibly skillful --

A Someone who can follow this kid and see if the kid conforms to those who really are going to change their gender identity at post puberty and be treated according to the protocol, or we're going to wait it out and see what happens.

Q Now, based on that statement, I want to ask a follow-up. Would a non-psychologist, let's say a person with a high school diploma, for example, be able to make that determination that you just described?

A No.

MR. GANNAM: Let's break for lunch.

(A luncheon recess is had from 1:30 p.m. to 2:04 p.m.)

BY MR. GANNAM:

Q All right. Are we back on?

All right, Dr. Spack. Going back to your

declaration, Exhibit 36, I want to ask you a few more questions about it. Can we look at page three and numbered paragraph seven that begins "multiple professional organizations."

Do you see that?

A Yep.

Q All right. In that paragraph, it says [as read]: Multiple professional organizations have issued evidence-based guidelines and standards of care for treating transgender and nonconforming children and adolescents.

Did I read that correctly?

Did I read that correctly, Dr. Spack?

A Yes.

Q Next, you write [as read]: I am familiar with these guidelines and standards which include the World Professional Association for Transgender Health, the American Psychological Association, the American Psychiatric Associate, the American Medical Association, and the Endocrine Society.

Did I read that correctly?

A Yes.

Q Now, these standards and guidelines of care that you have identified in this paragraph, I want to take them one by one. Beginning with the last one, the

Endocrine Society guidelines are the guidelines attached to your declaration as Exhibit B; correct?

A No.

Q No. What are the Endocrine Society guidelines?

A Well, it's ten years newer than that.

Q What would be the date, then?

A November -- it's actually 2018.

Q Now, those guidelines are not attached to your declaration; correct?

A Right. And I'm sorry about that. I thought -- I didn't realize that they had actually come out.

Q The World Professional Association for Transgender Health, is that the same as WPATH?

A Correct.

Q And do you say WPATH to shorten that? How do you pronounce that?

A That's what generally is said.

Q WPATH. Okay. I'm going to show you a document that I will mark as Exhibit 37.

(Exhibit 37 was marked.)

BY MR. GANNAM:

Q This document has WPATH on the top left and on the cover it says [as read]: Standards of care for the

health of transsexual, transgender, and gender-nonconforming people.

Lower right along the edge, it reads "version seven." Did I say that correctly?

A Um-hum.

Q And when I open to the first page after that cover, I see [as read]: Copyright 2012, World Professional Association for Transgender Health, WPATH.

Am I reading that correctly?

A You are. And I don't know what the frequency of publication is to be able to -- do you know whether this is most recent issue?

Q Well, that was going to be my question for you since you say in your declaration that you're familiar with the guidelines and standards and you identified World Professional Association for Transgender Health. I wanted to ask you, are these the most current WPATH standards of care?

A Look, they don't usually come out that frequently.

Q Have you seen this version that I marked as Exhibit 37?

A I believe I have.

MR. MIHET: Dr. Spack, would you be able to speak up just a little bit? I'm having a hard time

hearing you.

THE WITNESS: All right.

MR. MIHET: Thank you.

THE WITNESS: All right. Here we go. Page ten.

BY MR. GANNAM:

Q Okay. Is there something on page ten you wanted me to look at?

A Yeah. I'm just looking at...

Q Let me do this. I can represent to you that when I go to the WPATH website, this is the latest version available to me, but it's not my testimony that matters. So I just -- my question is, Are you aware of any later version than what is in front of you as Exhibit 37?

A I am not.

Q What is the significance of WPATH in this field that you practice in?

MR. WILLIAMS: You mean the organization?

BY MR. GANNAM:

Q The organization.

A The organization is really mixed. It does not define itself by specialty or skill. It is open to people who are all manner of mental health professionals and as well as endocrinologists, both pediatric and

adult. And even some surgeons.

Q Is it a membership organization?

A Yes.

Q Are you a member?

A Yes, actually.

Q How long have you been a member?

A I would say 15 years.

Q As you sit here, can you tell me whether this is the version you were referring to in paragraph seven of your declaration?

A Yes, I believe it is.

Q Are you aware of anything -- strike that.

Will you look at page eight of this WPATH, Doctor? In the bottom paragraph, the fourth line down is the word "often."

Do you see that?

A [As read]: Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize.

Q Those last three words were "masculinize their body"; correct?

A Correct.

Q Is that still a true statement in 2019?

A Well, knowing who these people are who wrote it, I think that it's a mistake not to define the age that they're talking about.

Q All right. What clarification would you add to make that sentence true in your opinion?

A Well, I would like it to say either -- and this is the case in both adults and children. See, I read this and I look at this and I see the adults that I've cared for. Just a pure gut feeling, and a little knowledge.

The two people who wrote -- the people who wrote, who are in parentheses are all treaters of adults. Bockting...

Q Meaning that the citation preceding this sentence that reads [as read]: Bockting & Goldberg, Bockting and Lev?

A Yes.

Q Is that who you're referring to?

A Yes.

Q And you know their practices or that they are practitioners?

A Yeah.

Q Okay.

A And this distinguished practitioner. But I don't know that they've ever seen a kid.

Q Now, you said, I believe a moment ago, that the statement would be true with respect to children and adults; correct?

A No, I didn't say that.

Q Okay.

A Or if I said it, I didn't mean it that way.

What I think that -- I think that they should make clear who they're talking about. And if they're talking about children and adults, say it.

MR. WILLIAMS: "They," the authors of this Exhibit 37? Is that what you meant, Doctor?

THE WITNESS: Yeah.

BY MR. GANNAM:

Q Dr. Spack, who wrote these WPATH standards of care? Or do you know?

A It'll say on front.

Q So on page one --

A Page one.

Q -- has a listing beginning with the name Eli Coleman; is that correct?

A Right.

Q Now, your name is not on this list?

A No.

Q Okay. I see -- okay. I'm not going to count, but I see roughly 20 or so people --

A Right.
Q -- maybe even 30?
A Okay. And I can --
MR. WILLIAMS: It goes all the way from Coleman down to Ken Zucker; right? That whole list of people? Is that what you're talking about?
THE WITNESS: Right. And out of this, and I know just about everybody here. I see Peggy Cohen-Kettenis. These are following who I would trust with this -- with comments about children or adolescence, would be: Peggy Cohen-Kettenis, Rob Garofalo, Arlene Istar Lev, Heino Meyer-Bahlburg. And I would delete Ken Zucker.
BY MR. GANNAM:
Q Okay. So understanding that this group of people are listed as the authors here, going back to page eight, the authors state -- let me read the whole paragraph. [As read]: As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither.
Did I read that correctly?
A Yes.
Q And then the next sentence reads [as read]:

Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body.

Did I read that correctly?

A Yes.

Q My question is, Does that statement, beginning with "often with the help of," apply to minors; that is, persons under the age of 18?

A I think -- well, depends what you call minors. If I were talking about minors who have just reached puberty, I would say that it does not.

It's certainly not with the kind of certitude that is written here that was much more applicable to adults. And I'll tell you why. And that is that the about-to-be -- the early pubertal kid who has major issues about gender identity, as puberty hits, they have a profound panic. My own philosophy about this is that what happens is they've been told that when they got through puberty, they wouldn't feel gender dysphoric anymore. And the fantasy that they're going to turn into the other gender is not realized and they decompensate.

But the adults, their bodies are essentially finished. And being finished, they feel they have more

choice. Do you know what I mean? My body's finished and, well, am I going to go through all this that's going to not do such a great job of having me look like a woman or like a man. And I've seen it. I mean, I've seen these -- they -- of course, they may be amendable, more amendable to psychotherapy because the psychotherapist is pointing out to them all the issues and problems and challenges and physical and maybe familial and everything else.

So I have trouble when I read somebody who writes with this kind of certitude, knowing that the kids I see are in terror.

Q Well, let me ask you about --

MR. WILLIAMS: What was that last word? Terror?

THE WITNESS: Yeah.

MR. WILLIAMS: Oh.

BY MR. GANNAM:

Q This statement on page eight, if it were revised to leave off the first qualifier there "often," and I just began with the word "some," and I changed it as follows: Some prepubertal children integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body.

Would that be a true statement?

MR. WILLIAMS: Object to the form of the question as an improper hypothetical which assumes speculative facts, frankly.

Go ahead and give an answer to the question, if you can, Doctor.

THE WITNESS: Well, "some," would apply to anything. But the way this is written is more like "often." And I would never write -- I could accept it writing with "some." But if they -- but I would not accept it being included in "often."

BY MR. GANNAM:

Q Understood. Let me move on then and look at something a little more specific. Page 11 contains the beginning of a section titled "differences between children and adolescents with gender dysphoria."

Do you see that?

A Yep.

Q First sentence [as read]: An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.

Let me stop there. Have I read that correctly?

A Yes.

Q And do you agree with those two sentences so far?

A Yes.

Q And just so we're clear, when this uses the term "gender dysphoria," are we to understand that to mean a disagreement or incongruency between the child's biological sex and the child's gender identity or the gender the child believes the child is closer to or matches better?

A I think it gets the statement across.

Q So let me continue. It says [as read]: Rather, in follow-up studies of prepubertal children, mainly boys, in parentheses, who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only six to 23 percent of children.

Did I read that correctly?

A Yes.

Q And then after the long citation -- or after the citation -- actually, just go down to the sentence begins "newer." It says [as read]: Newer studies, also including girls, showed a 12 to 27 percent persistence rate of gender dysphoria into adulthood.

Did I read that correctly?

A Yeah.

Q Now, this document shows a date of 2012 on it. Are you aware of any studies that alter these numbers that are presented here as the range of boys and girls whose gender dysphoria persists into adulthood?

A No. But I'm always -- and I don't disbelieve the basic point here. But I do want to point out that sampling, in other words -- well, I trust Cohen-Kettenis.

When I read Zucker, makes me wonder because his patients are coming into a place that says psychiatric clinic.

However, let's go -- let's go on because the key thing is what they say about adolescents.

Q Right. Well let me read that, then, the next paragraph begins [as read]: In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist.

Did I read that correctly?

A You did. And I think that this -- pairing these two makes perfect sense.

Q "These two" meaning that first paragraph --

A That first paragraph.

Q -- and the two sentences I just read?

A Yes. And it has some obligation. Just the fact that many of these kids won't persist doesn't mean they don't need support or doesn't mean that if they are very much compromised by, if not allowed to live in the opposite role, even if it's temporary, it should be allowed.

Q So you're speaking of some ethic of client determination or freedom here?

A Right.

Q Okay.

A And what you see here, and this is really important, why did the Dutch, why do we, why do all the places around the world that are doing pubertal suppression start with the first sign of puberty? And the reason for that is the data show that a kid who holds on to the idea that he's in the wrong or she's in the wrong body at puberty are almost definitely transgender.

Q Can I ask for your opinion on the second sentence of that second paragraph that I just read "no formal prospective studies exist." Is that still the case?

A I would say that if anybody has that data, it would be the group listed in the bottom. And let me just see.

Q The bottom of...

A So you see, what they say is that -- now they talk about -- see where it says [as read]: However, in follow-up study with 70 adolescents --

Q Right.

A -- who were diagnosed with gender dysphoria and given pubertal suppression? All continued with actual sex reassignment. In other words, they were suppressed in puberty, but when they -- they all wanted the hormones consistent with their new gender identity.

Q And so there's a citation after that sentence to de Vries, Steensma --

A Right.

Q -- Doreleijers.

A This is the -- you're seeing the names of the Dutch group, de Vries, the psychiatrist is head of the group. Steensma is a endocrinologist. I don't know the next one. Cohen-Kettenis was the former leader of the group. She's now retired.

Q So the statement in this 2012 document says "no formal prospective studies exist." And I believe you're saying this Dutch group would be the people to ask if that's still the case?

A Right.

Q But as you sit here, do you know the answer?

A And I kind of have a feeling, is that they got so involved in the pubertal suppression that they had no doubt that these kids -- these kids would not have been enrolled in their study if they didn't have the testing that showed they are -- they're transgender. So I don't know why they put it this way.

Q But are you aware, personally, of any studies that exist or that came out after this statement that the authors of this document made, which is that no formal prospective studies exist?

A No. And part of that is that it's really -- it's -- they could be such studies, but you have Zucker who would be one of the authors. And he was so eager to treat that we don't really know what his patients were like before treatment.

Q So apart from speculating about Zucker, you're not aware of any --

A No.

Q -- formal prospective studies; correct?

A No.

Q Am I correct?

A I think so.

Q Okay. Thank you.

Let's -- the bottom of that page 11, it says "as discussed in section four," do you see that?

A Yep.

Q It says [as read]: As discussed in section four and by Zucker and Lawrence, 2009, formal epidemiologic studies on gender dysphoria in children, adolescents, and adults are lacking.

Do you agree with that statement?

A Yes.

Q And what does epidemiologic mean?

A Population studies.

Q Great. I'm going to show you a document I've marked as Exhibit 38.

(Exhibit 38 was marked.)

BY MR. GANNAM:

Q This document is from the American Psychiatric Association. The title is "a guide for working with transgender and gender-nonconforming patients."

And what follows is sort of a table of contents. This is from a website. I accessed it from the American Psychiatric Association website. And my question for you is, Is this guide, at least as it's laid out here, the American Psychiatric Association guidelines to which you refer in paragraph seven of your declaration?

MR. WILLIAMS: Object to the form because obviously Exhibit 38 is -- I don't know that he can

really answer your question, Roger, but...

THE WITNESS: So the only question really that you can ask with a document like this is, Does this -- does this table of contents conform to what you would expect of a document on the subject by the American Psychiatric Association.

BY MR. GANNAM:

Q Let me ask you this question: You refer in numbered paragraph seven on page three of your declaration to various guidelines and standards of which you specifically identified the American Psychiatric Association; correct?

A Right.

Q So --

A But I saw something a lot more than this.

Q Okay. And so is this a -- did the document you saw, for example, have the same title as this document, "a guide for working with transgender and gender-nonconforming patients"?

A Yes. But you know when it says "view more"?

Q Right. Well, let me ask you next, then. Does this listing of contents, understanding this was printed from a website where you could click on each of these things and view more, does this listing of contents correspond to the document that you were referring to in

the -- in your declaration?

A Yes.

Q Okay.

A If I were writing this for them, these are the -- these are the headings I would --

Q Let me ask you to look at the second to last page of the document that I gave you where it says "about the guide."

A About the guide.

Q Do you see that?

Under "disclaimer," the second paragraph, it says [as read]: Many experts have studied gender and sexuality throughout their careers. This toolkit represents just one view of how to work with TGNC patients, based largely on the WPATH standards of care. Did I read that correctly?

A Okay. Yeah.

Q Is that consistent with your understanding of the American Psychiatric Association guideline you refer to in your declaration?

A It doesn't surprise me at all.

Q Okay. Understand, I haven't given you --

A No, but...

Q -- the entire document to work with. But are you aware of some other document besides what I've given

you the title and contents of in this Exhibit 38 by the American Psychiatric Association, that you're referring to in your declaration?

A No, I'm not. And I was pleased to see the topics and less pleased to see the text.

Q Understood.

A It doesn't -- that doesn't surprise me with this organization.

Q Going to footnote asterisk in your declaration, you identified in that footnote several documents of which you are the author or co-author; correct?

A Yes.

Q And you mentioned the first couple of them as possibly containing some information relevant to your -- the contents of your declaration, generally speaking; is that correct? Actually, strike that.

I'm just going to show you the document. This is marked as Exhibit 39.

(Exhibit 39 was marked.)

BY MR. GANNAM:

Q The title is "management of transgenderism" in a publication from JAMAnetwork.com. It says Norman P. Spack, MD, discussant as the author. Is this the same document identified in footnote asterisk as Spack, NP,

clinical crossroads, management of transgenderism, JAMA 2013-209?

A Yes.

Q Okay. So this is a document you authored; correct?

A Yes.

Q I wanted to ask you about the bold paragraph at the top right appears to be some kind of abstract or summary. Would that be fair to say?

A Yes.

Q It talks about gender identity disorder, or in parentheses, transgenderism to begin the paragraph. Did I read that correctly?

A Yes.

Q It says [as read]: Gender identity disorder (transgenderism) is poorly understood from both mechanistic and clinical standpoints. Awareness of the condition appears to be increasing probably because of greater societal acceptance and available hormonal treatment.

Have I read that correctly so far?

A Um-hum.

Q Then it says [as read]: Therapeutic options include...

And it gives a listing of male to female and

female to male therapeutic options; is that correct, generally?

A Right.

Q I'm going to skip down towards the end, the sentence begins "medical therapy." Did I say that correctly? Or do you see that?

A Yes.

Q Now that sentence says [as read]: Medical therapy for both FTM, defined above as female to male, and MTF, defined above as male to female, can be started in early puberty, although long-term effects are not known.

Did I read that correctly?

A Yep.

Q Now, where it says medical therapy, is that referring generally to the listing of therapeutic options that appeared before it?

A Yes.

Q And you wrote this -- or this was published in 2013. Is the statement "although long-term effects are not known" still a true statement?

A Yes.

Q All right. I'm going to show you another document now. This, I will label Exhibit 40.

(Exhibit 40 was marked.)

BY MR. GANNAM:

Q Will you take a look at Exhibit 40 for me? The title of this document is "serving transgender youth, challenges, dilemmas, and clinical examples."

The main heading says "HHS public access, author manuscript."

Below that, it says [as read]: Published in final edited form as professional psychology -- I guess that would be research and practice, 2015.

Is this the document identified in your declaration footnote, the first document there, as Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel F. H. --

A Yes.

Q -- Shumer, D. H., and Spack, N. P., 2015?

A Yes.

Q Yes. Thank you. So this is a document you co-authored; correct?

A Correct.

Q Will you look at page four, please? The first paragraph, the last sentence begins members of the GeMS team.

Do you see that?

A Page four?

Q Yes.

A First paragraph.
Q Last sentence of the first paragraph.
A Okay.
Q First of all, what is GeMS?
A Gender Management Service. That is the name of our clinic where we see kids in gender --
Q In Boston?
A Yeah. Boston Children's.
Q All right. So members of -- do you say GeMS? Is that how you pronounce it?
A Yeah.
Q Okay. So members of the GeMS team have played a role in the development of standards and guidelines, including as a member of the active APA task force to develop guidelines for psychological practice with transgender and gender-nonconforming clients. Did I read that correctly?
A Yes.
Q Now, did you personally participate on that APA task force?
A No.
Q Are you aware of that task force and the document that it was bearing?
A Yes. And I'll tell you why.
Q Okay.

A We benefited from -- you can see the names of the Dutch up above who gave us their testing materials to determine gender -- gender identity and gender dysphoria. And we had it translated from the Dutch. But we needed to be able to -- we got permission from the Dutch that the task force was literally translating and establishing something that we could pass around to all these new 70 clinics.

Q I see. We'll come back to those APA guidelines. I want to ask you a few more questions about this document.

Will you look at page seven?

MR. WILLIAMS: Page seven.

THE WITNESS: Yep.

BY MR. GANNAM:

Q Under the heading "medical intervention," do you see that?

A Yes.

Q The second paragraph under that heading, the last sentence begins with the word "nevertheless."

Do you see that?

A Okay.

Q It says [as read]: Nevertheless, an adolescent who has initiated puberty blockers can decide to terminate the intervention and allow physiological

changes to occur as they would have had the medical intervention never been initiated.

Did I read that correctly?

A Yes.

Q Now, just for the record, puberty blockers, is that what we've already discussed as drugs that can be administered to a child to stop the progression of puberty?

A Yes.

Q And this statement seems to be claiming that puberty blockers can be administered, but then stopped, and then --

A It's completely reversible.

Q Meaning puberty will begin where it left off, so to speak?

A Exactly.

Q Okay. Now, is there any study or research pointing to what harms may occur in a person who delays puberty such that they take puberty blockers and then stop puberty blockers and recommence puberty, but at an older age than they otherwise would have or then their peers went through puberty?

A It would only be an issue if the -- if they were on them all the way through puberty and stopped them close to a time of desired fertility. Because when

you're on them, they're shutting down the whole system.

Q What do you mean "the whole system"?

A The whole system that leads to spermatogenesis, leading to testosterone production. And in the case -- in our usual case, that genetic male who affirms a female identity, around age 17 and 18, is going to want to have what I call a feminizing genitoplasty. In other words, female external genitals.

In the course of doing that, the testes are removed.

Q Which is an irreversible --

A It's as irreversible as it gets. But the point is, it's -- so the issue for us in this regard is usually moot because the patients are told well ahead of time, if you go this far, they're going to have to do a -- remove the testes.

Q So would it be accurate to say the effects of puberty blockers are reversible up to a point in time after which they no longer would be reversible?

A Well, they would be -- believe it or not, they -- your ability to generate the hormone that you're blocking will still be there.

Q Okay.

A Okay? The point is that if someone besides, well, I'm not sure I want to have feminizing

genitoplasty, but please keep the blocker going so I don't have to shave and I don't this or that, and then decided at some point wanted to procreate, given a few years, all spermatogenesis would reoccur.

Q So in that sense, it's reversible in that those biological processes will kick in again?

A Right.

Q Okay. Next paragraph on the same page seven reads [as read]: Only with an older adolescent, typically around age 16, are irreversible interventions initiated, and only after psychotherapy and a careful psychological evaluation has taken place.

Did I read that correctly?

A Yes.

Q Can you kind of summarize for me, what are the irreversible interventions that could be initiated around age 16?

A So I'm trying to see if they're referring to males or females; right? It looks like they are.

So, they're talking about the institution of the actual hormones of the affirmed gender. Okay? And once you do that, you get breasts whether you want them or not. You get body hair, you get larynx. You get lower voice if you get testosterone.

Q Did you just describe some examples from both

sexes?

A From both, yeah.

Q Okay.

A And so it's going to happen. And that's why we test them before we -- because this is the first time that we, at around age 15, 16, the first time that we do give irreversible treatment.

Q So within the standards or guidelines of practice that you operate under, there is a -- a range of ages under 18, you say around 16 here, at which a minor can elect to kind of cross that threshold of irreversible treatment, beginning with cross-sex hormones. Is that --

A Yeah. I would say it's 15 to 16.

Q Okay.

A Would be the case.

And 18 is a timing of surgery, if desired.

Q Now, is that a -- is 18 an absolute? Or are there situations where persons under the age of 18 may elect and proceed with surgical interventions?

A Yes. You raise an interesting point. We used to say 18 because that was a legal age of consent. However, the surgeons have told us that the worst outcomes that they have in feminized genitoplasty where the patients have to use dilation for four or five times

a day for a year that we, in the past, were sending girls to the surgeons during the summer before their going off to college, if 18.

They tell us that the worst results they have are with them because the first year requires strict adherence to the dilation protocol. They can't do it at school and they don't.

Q Can you, just for the record, explain what you're talking about, about the dilation protocol for --

A Well, they create a new vagina, and believe it or not, using inverted scrotal tissue.

Q This would be in a male to female --

A A male to a female.

Q -- surgery.

A Right.

Q Okay.

A So that tissue needs to be expanded to be functional, for them to be sexually functional.

And it works. But unless the initial dilation after the surgery is required to keep the patent.

Q What does that dilation involve? Is it something that would have to be --

A It looks a lot like a vibrator really.

They may have a series of gradations of size. But they have to do it. If they don't do it, what

happens is they go back to the doctor, the spring after their operation, and the doctor finds he can't get the dilator in, in which case, he has to do another surgery to cut a slit in the upper part of the vaginal wall. And it's a mess.

So we've kind of shifted and said, Okay, a girl has to be in her mother's territory for the first year after surgery, because the mother can make sure that the girl does the dilatation. Otherwise, the girl goes off to school, is so happy to be free, this or that, and doesn't do it.

Q And can you articulate a reason why the -- why a child or adolescent, I guess, who has undergone this surgery might not continue with the dilation? Is it laziness? Is it painful? What is that?

A It's laziness. It's the fact that you have to be -- first of all, if you go to college, they have to have a single room. They have to dilate on their bed. You can't share a room with someone doing that.

Secondly, their classes are so much farther from their dorm to do four or five dilations a day. It's just physically impossible.

Q I see. On page eight --

MR. WILLIAMS: We're still on Exhibit 39? 40.

MR. GANNAM: 40, actually.

BY MR. GANNAM:

Q I'll just read the whole paragraph. The second -- or the first full paragraph --

A What page?

Q Page eight. Begins "a common scenario."

A Okay.

Q [As read]: A common scenario for GeMS to recommend puberty blockers -- strike that. Let me start over.

[As read]: A common scenario is for GeMS to recommend puberty blockers when the youth and/or the parent may feel that it would be best to start cross-sex hormone therapy instead. The delay of puberty, rather than the immediate onset of the puberty of choice, (utilizing cross-sex hormones) is sometimes difficult for the youth or family to accept. This is an area where we currently have little research to guide us and the decision of whether to block puberty or instead move forward with an affirmed gender, i.e., cross-sex hormones, must be weighed carefully.

Did I read that correctly?

A Yeah.

Q Is that still a true statement that this is an area where we currently have little research to guide us?

A Because very few people should, would, or should do it this way.

And the reason is that, say, you're dealing with a genetic female. And they want to go right forward into a male puberty -- into a male puberty. Okay? If you don't block them while you're doing it, there's going to be menstruating. They have to understand that she's going to be menstruating like a female, she's going to get progressively large breasts that may require a more complex operation. And it's why my way of doing things and most of the people follow me is that I run the blockade medicine all the way until the gonads come out. So therefore, the person who's male to female has no masculinization, but at age 15 is getting feminization. So there's a person who comes out looking perfectly female in the end because they don't have any male characteristics while they're going through a feminine puberty.

So, you know, if I had a situation like this, I would say forget it.

Q So the statement that "we currently have little research to guide us" refers specifically to that decision of whether to simply block puberty or move ahead with cross-sex hormones?

A Yeah. I remember seeing this and I said,

well, I understand that you could put it in there because unfortunately, a lot of people can't afford the blocking hormones. And we've got to do something. So this is what we do, is to give them the hormones they desire. They get some of those characteristics. But it's not ideal.

Q Now, the last sentence reads [as read]: Aside from the irreversible nature of cross-sex hormone initiation, this intervention has significant ramifications for fertility while puberty blockers do not.

Did I read that correctly?

A Yes. For example, you have a -- you give excess or masculinizing testosterone levels to a genetic female, you're going to end up making her what we call polycystic ovary disease. She's going to have big cysts in the ovaries. She's going to have trouble conceiving.

Ironically, the just shutting down puberty just lift it up when you want to...

Q Will you look at page 11, please? The heading reads "the service gaps and evolution of practice."

Did I read that correctly?

A Yeah.

Q Now, this reads [as read]: Watching the clinical services grow is rewarding, especially when

they translate into more contented and peaceful lives for youth and their families. Nevertheless, evidence-based practices are aspirational when a new field emerges with no guiding clinical precedent. Controversies among providers in the mental health and medical fields are abundant.

Did I read that correctly?

A Yes.

Q Okay. Now, the next sentence reads [as read]: Drescher & Byne, 2012, and Stein, 2012, provide excellent discussions of issues of consensus versus continued controversies. These include differing assumptions regarding whether early intervention with gender variant youth can encourage the assistance, and whether that is an appropriate practice.

Did I read that correctly?

A Yep.

Q It continues [as read]: Other areas of debate include the age at which children or adolescents should be encouraged or permitted to socially transition, whether cross-sex hormones and surgery should be offered to youth, and if so, at what age, whether parental consent be required for these medical interventions, and whether mental health involvement be required including psychological evaluation prior to each stage of medical

intervention.

Did I read that correctly?

A Yes.

Q [As read]: These issues are complex and providers in the field continue to be at odds in their efforts to work in the best interest of the youth they serve.

Did I read that correctly?

A Yes.

Q And this is a 2015 document. Is it still the case that these complex issues of disagreement continue?

A Yes. But, you know, I would like to make one point. This is why we're a team. This is why every patient is discussed before they're in the clinic they're going to come in at, and everyone has a role about how the patient feels about this and helps to make these complex decisions.

There are also a reason why we're here today, in part, because of alternative ways of going at this issue, albeit it somewhat of an early issue. Who knows. This is what I -- I can worry about this because I think in time we can get the right answers to it.

But I can't worry for my patients who's seeing somebody who may have a theological basis for how they're going to treat the patient, or where I worry

whether the person who is benefiting the most is the patient or the clinician. And these are tough-enough issues, even when you have all the tools.

The people on my team can handle these decisions with this stuff.

Q The next paragraph begins "an important priority."

Do you see that?

A Yep.

Q [As read]: An important priority. Going forward is to develop research to enhance our understanding of what typifies this population of children and their developmental course and patterns and to examine the long-term outcomes of treatment.

Did I read that correctly?

A Yes.

Q [As read]: The field needs to better comprehend which children are most likely to have a lifelong and persistent identification with a different gender than the one they were assigned versus those who cease to self identify as transgender over the course of time.

Did I read that correctly?

A Yes.

Q [As read]: Although some information is

available -- there's a parenthetical with several sources listed -- much more research in this area is needed.

Did I read that correctly?

A Yes.

Q Is that still a true statement, that much more research in this area is needed?

A Yes. But what you're reading is the marching orders of why we would grant.

Q Okay. You're talking about the $6 million NIH grant that was awarded?

A Right.

Q All right. I'm going to show you a document I've marked as Exhibit 41.

(Exhibit 41 was marked.)

BY MR. GANNAM:

Q All right. This document is titled "practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescence."

At the top is a filing header from this lawsuit reading case 8:17-cv-02896, document 24-4, filed January 12, 2018.

And I'll represent to you that this is a document filed in this lawsuit by the City of Tampa as

one of the documents referenced in its ordinance. Have you seen this document before?

A No. Who is the author?

Q The American Academy of Child & Adolescent Psychiatry, AACAP.

A Without listing any --

Q I'm sorry?

A Without listing any particular individuals? This is like a -- this is a -- is this like a, say, statement by...

Q Well, if you look on page 971 towards -- 971 using the page numbering at the bottom of the pages.

MR. WILLIAMS: Excuse me. Just a second so I can catch up. Okay.

BY MR. GANNAM:

Q You see where it says "parameter limitations"?

A Okay.

Q And then below that is a box, a gray box, "this practice parameter was developed by"?

A Okay. It's like attachments.

Q Correct. So are you familiar with this document?

A No.

Q You're not? Okay. Fair enough. I'll move on, then. All right. Now I'm going to show you a

document previously marked as Exhibit 33 when we had the deposition of Dr. Glassgold. And it's an APA document, "guidelines for psychological practice with transgender and gender-nonconforming people."

(Off the stenographic record.)

MR. WILLIAMS: I can't tell. Is that the '09 document?

MR. GANNAM: This is the 2015 APA document.

MR. WILLIAMS: Oh, the 2015. Okay.

MR. GANNAM: For the record, it was filed in this case at document 135-1.

(Exhibit 33 was marked in a previous deposition.)

BY MR. GANNAM:

Q Now, do you recall when I asked you about your article that referred to GeMS team members participating on the APA task force on the development of guidelines for psychological practice with transgender and gender-nonconforming people?

A So you're looking at number 33?

Q Yeah. Let me ask you -- let me back up.

Will you look at document 40 again, which is your article and the HHS public access page. And go to page four of Exhibit 40. And on page four, the first paragraph, last sentence --

MR. WILLIAMS: Page four?
MR. GANNAM: -- of page four of document 40.
MR. WILLIAMS: Oh, this one. Okay.
BY MR. GANNAM:
Q I think you're on the right document.
The last sentence of the first paragraph reads "members of the GeMS team."
Do you see that?
A I'm sorry, what page?
MR. GANNAM: May I point to it, Rob?
MR. WILLIAMS: Sure.
BY MR. GANNAM:
Q We're on page four. And this, "members of the GeMS team."
Do you see that?
A Okay.
Q It reads [as read]: Members of the GeMS team have played a role in the development of standards and guidelines, including as a member of the active APA task force to develop guidelines for psychological practice with transgender and gender-nonconforming clients.
Did I read that correctly?
Dr. Spack, did I read that correctly?
A Yep.
Q Now, this document that I handed you just a

moment ago marked Exhibit 33, is that the document being referred to that your GeMS team played a part in?

A Yes.

Q I didn't hear if you answered or not.

A Yes.

Q Oh, okay. Are you familiar with these APA guidelines?

A I have seen them, yes.

Q Okay. Have you had an opportunity to develop any opinions as to their accuracy?

Let me stop there.

A Well, if I looked at this, I looked at it casually. I'm not a great fan of the APA.

Q Okay. Fair enough. Let me just ask you some specific questions about it, then.

Will you look at, using the page numbering at the bottom of the pages, page 842 of the document.

MR. WILLIAMS: You're talking about that?

BY MR. GANNAM:

Q Yeah. Exhibit 33.

A Okay. Okay.

Q On page 842, the first full paragraph begins with "a clear distinction."

Do you see that?

A Um-hum.

MR. WILLIAMS: Are you going to read that into the record, Roger, since I don't have a copy? It might be helpful for me to follow that.

MR. GANNAM: Yeah. I'll read the whole paragraph.

MR. WILLIAMS: Thank you.

BY MR. GANNAM:

Q Are you with me on the page, Dr. Spack?

A (No verbal response.)

Q Is that a yes? Sorry. Just for the record.

Did you say yes, Dr. Spack?

A Yes.

Q Okay. Thank you. [As read]: A clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature. Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children.

Did I read that correctly?

A Yep.

Q Now, I'm going to break that down into a couple of pieces and ask you about it. First, where it says TGNC, you understand that in this document, that

means transgender and gender nonconforming?

A Um-hum.

Q Okay. Great.

MR. WILLIAMS: You have to say yes.

THE WITNESS: Yeah. Yeah.

BY MR. GANNAM:

Q All right. So that's a yes?

A Yeah.

MR. WILLIAMS: For her benefit.

THE WITNESS: Yes.

MR. MIHET: And try to keep your speech up, if you can. I'm still having a hard time hearing you across the table.

MR. WILLIAMS: What did you say?

BY MR. GANNAM:

Q So it says [as read]: Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood...

So first, do you agree with that premise that not all children persist with a TGNC identity? Do you agree with that, Dr. Spack?

A Yep.

Q The next premise is [as read]: And because no approach to working with TGNC children has been adequately, empirically validated...

Do you agree with that premise, that no approach to working with TGNC children has been adequately, empirically validated?

A Yes.

Q Then the final statement is [as read]: Consensus does not exist regarding best practice with prepubertal children.

Do you agree with that conclusion that consensus does not exist regarding best practice with prepubertal children?

A I think it's poorly written because I don't think that they're indicating what kind of practice they're referring to. They should indicate -- we, somebody, they, should indicate should we encourage children to assume a social role, even if temperate.

Q Sorry, could you say that again?

A Well, it's not giving you a choice -- any idea of what would be a potential way of dealing with prepubertal children.

Q Okay. Well let me -- let me -- okay. So apart from that criticism of the statement, is it nonetheless a true statement that there is not a consensus regarding the best practice with prepubertal children?

A I would say the answer to that is yes. And

part of the reason our clinicians, like Zucker, who have confused the physicians who would take care of these children.

Q So it identifies, then, two distinct approaches. If we skip down a sentence, it begins "two distinct approaches."

Do you see that?

A Um-hum.

Q Is that a yes?

A (No verbal response.)

Q I'm sorry. I need you to say --

A Yeah.

Q I know it can be cumbersome.

But [as read]: Two distinct approaches exist to address gender identity concerns in children.

Then after the citation it says [as read]: With some authors subdividing one of the approaches to suggest three.

Now, the next paragraph begins [as read]: One approach encourages an affirmation and acceptance of children's expressed gender identity.

Did I read that correctly?

A Yes.

Q And, in fact, in the middle of that paragraph, it even refers to one of your articles; correct?

A Yes.

Q Okay. Now, the next paragraph says [as read]: In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. This includes endorsing and supporting behaviors and attitudes that align with the child's sex assigned at birth prior to the onset of puberty.

Did I read that correctly?

A Yes.

Q Are you in agreement with the general proposition that there are two approaches to prepubertal children, one being to encourage and affirm the express gender identity, and the other approach to encourage children to embrace their given bodies that align with their biological sex?

A Absolutely.

Q Okay. I want to ask you to look at page 843, using the page numbers at the bottom. Have you found page 843?

A Yes.

Q On the right column, in the last paragraph, it begins "psychologists may encourage."

Do you see that?

A Yes.

Q If I skip down one, two, three sentences to the sentence that begins with the word "emphasizing"?

A Yes.

Q You see that. Great. I'll read it. [As read]: Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated, particularly given the research that suggests that not all young gender-nonconforming children will ultimately express a gender identity different from that assigned at birth.

Did I read that correctly?

A Yes.

Q Do you agree with this admonishment or this advice in this document?

A Yes.

Q Okay.

MR. WILLIAMS: Can we take a break real quick?

MR. GANNAM: Yes, we may.

(A brief recess is had from 3:18 p.m. to 3:30 p.m.)

BY MR. GANNAM:

Q Dr. Spack, can I ask you to go back to your declaration, which is Exhibit 36?

A Okay. Where abouts?

Q And page three, which is the section Roman numeral two, "analysis and opinions." Are you there?

A Yes.

Q All right. Will you look at numbered paragraph one? It reads -- are you at that paragraph?

A Yeah. "I have reviewed."

Q It says [as read]: I have reviewed the declaration submitted by Dr. Bernard Hudson. From that review, it is my professional opinion that the declaration significantly misstates current medical knowledge and practice regarding the standard of care and treatment for transgender and gender-nonconforming children and adolescents.

Did I read that correctly?

A Yes.

Q Does this paragraph mean that you disagree with everything Dr. Hudson said in his declaration?

A No.

Q In your declaration, apart from this paragraph one, do you identify any specific part of Dr. Hudson's declaration that you disagree with?

A Do you have his declaration?

Q I'm asking if, in your declaration, after this paragraph one --

A Oh, oh, oh, okay.

Q -- do you specifically identify any part of his declaration that you disagree with?

A There's no significant evidence that any type of therapy or treatment can change a person's gender identity.

Q Where are you reading? Are you reading --

A Number four.

Q Okay. Number four reads [as read]: There is no scientific evidence that any type of therapy or treatment can change a person's gender identity. And attempts to do so put patients at risk of serious harms, including suicidality and depression.

Did I read that correctly?

A Yes, you did.

Q Now, are you telling me that that paragraph disagrees with something in Dr. Hudson's declaration?

A Yes. He does not refer to the risks associated with trying to shoehorn somebody into a gender identity.

Q Now, in paragraph four when you say there's no scientific evidence that any type of therapy or treatment -- let me stop there.

Are you referring to what you earlier defined as conversion therapy?

A Yes, but -- yes.

Q Okay. So when you talk here about -- well, it says [as read]: Attempts to do so put patients at risk of serious harms, including suicidality and depression.

Did I read that correctly?

A Yes.

Q Now, you testified earlier that you're not a mental health professional. But I wanted to ask you if you know, is there some risk of harm, including suicidality and depression that can result from psychotherapy in general?

A That's true, but this is a particularly vulnerable population.

Q Okay. So you do agree it's true that psychotherapy in general can present some risk of harm of suicidality and depression to patients?

A Yes.

Yes.

Q Now, can you quantify for me what increased risk, if any, from what you defined as conversion therapy for suicidality and depression exists?

A Well, it may not be particularly scientific, but the first -- the first association I had with conversion therapy, and actually was the only one so far -- I'll tell you what happened.

This was a 18-year-old female who affirmed a male identity. The parents were very active in their Catholic church and tended to go along with some of the sign waving that the MassResistance organization was holding up in front of -- the objection of that organization to gay and lesbian teachers being allowed to teach in the schools.

I actually found this kid to be a fairly jovial person. I actually didn't consider him at high risk. His parents felt that he should have a go of therapy with a person who believed very much in conversion therapy and was also tied very much to this particularly right wing Catholic group that had made a fair bit of noise in Massachusetts.

Q That's MassResistance?

A MassResistance.

Q Okay.

A Hadn't seen him in a while. And I spoke to his parents. I said, How is he doing. Mom said, Well, I think he's developed a drug problem. Are you getting any help for that? We're going to try.

The next thing I heard, that he had still seen the therapist who was working on trying to convert him back to female. And the next thing I knew, I got a call from the parents that he had overdosed on heroin and

died.

Now, this is a complex situation, obviously. Any heroin death can often be mis -- taking too much or too strong a dose. And I understood that.

But I met with the parents and they were beside themselves. And they particularly put blame on themselves for forcing an issue and finding a person who would be their agent in that.

So I have a particularly -- I really liked this kid. This kid was a great hockey player and played with boys. I was a hockey player. And ironically, or maybe perhaps expectedly, the parents abandoned the MassResistance type -- abandoned that church altogether. They came to every lecture I ever gave in Greater Boston. They became the most active people to meet with new, newly diagnosed transgender kids. It was just quite amazing as to what happened. But just, what can I say? It was something that's very, very hard to forget.

Q As the parent of an 18 year old, I can't imagine. So obviously, that would be a situation that is sad on many, many levels. Can you say, as you sit here, that the drug overdose was caused by what you call the conversion therapy this young person received?

A I can't. I can't. All I can say is this: The initiation of drug treatment -- of drug taking --

this kid wasn't taking anything before -- was coincident with -- the actual overdose with heroin, I never ascribe the overdose to a voluntary suicide. Just can't.

Q Right.

A There's too many variables.

Q And so scientifically speaking, of course, coincident does not mean causal, obviously?

A Of course.

Q Now, do you know anything about this person that the parents chose as therapist? Was this person licensed or a religious leader? Or do you know anything about the person?

A I think the person came -- was recommended through the church and through -- whether the person was -- well, that's all I know.

Q Okay. Now, I understood -- you don't know whether the person was a licensed therapist; is that correct?

A No.

Q No, you do not know?

A No, I do not know.

Q Okay. Now, I got the impression from the way you explained what happened that this was also somewhat to some extent coercive where the parents sort of sent their son or -- you told me this was a --

A Female to male.

Q Okay. So the parents sent their child, who was 18 to this person, whoever it was.

A Right.

Q Well, I mean, obviously I can see why that account and their experience would put a bad taste in your mouth. But going back to the more scientific question, which is, can you put a percentage or quantify the increased risk to a person of suicidality or depression, or any poor mental health outcome, from conversion therapy as compared to psychotherapy, in general?

A The only thing is that he started using heroin after he first met the therapist. And he continued to use heroin for weeks until he took the overdose. And so there was a part of me that was feeling -- he told that therapist he was taking heroin -- why, you know, why didn't -- why didn't he get the kind of referral that you would expect.

Q I can see why you would have those questions.

MR. GANNAM: Can you read back my question to him, please?

(The Court Reporter is directed to read back the previous question and/or answer.)

THE WITNESS: I can't say.

BY MR. GANNAM:

Q You can't say?

A The only thing I can say is that whoever he saw was seeing a kid who was relatively new to any -- any drug. And this was heroin. And this person made no appropriate move.

Q So apart from that particular situation, are you telling me that you can't quantify or put a percentage on the increased risk from conversion therapy?

A Correct.

Q Now, what led me to that question was an earlier question about what specifically your declaration points to in Dr. Hudson's declaration that you disagree with.

Is there anything else in your declaration identifying a disagreement with Dr. Hudson's declaration?

A I will say one thing about -- or maybe I said this before. As I reread Hudson's declaration, I had the feeling -- I had the feeling that Dr. Hudson might be an appropriate therapist for some of my adult patients. That the way he came -- he comes across, a sensitive person, that even though some of his approach, perhaps, in conversion type would be totally

inappropriate for children and adolescents, it might be very useful in someone over 30 who literally needs to be shaken up a bit but with a tenderness.

Q Do you, in your declaration, identify anything that -- any treatment that would be inappropriate for a minor, based on Dr. Hudson's declaration?

A Well, I do make the points that subjecting minors to conversion therapy deviates from the standard of care for treating transgender and gender-nonconforming children in adolescence.

And I think that's the topic sentence for my issues with Dr. Hudson and the age group that I talk about.

Q Is there anything else in your declaration that points to a -- something specific in Dr. Hudson's declaration that you disagree with or found inappropriate?

A No scientific evidence in any type of therapy or treatment can change a person's gender identity. Attempts to do so put patients at risk of serious harm, including suicidality and depression.

Q That was paragraph four; correct?

A Right. And number seven, I won't read them all, but I listed the multiple professional organizations that have issued evidence-based guidelines

and standards of care for treating transgender and gender-nonconforming children in adolescence. By inference, I say that these -- none of these guidelines include conversion treatment.

Q All right. Have you now told me everything in your declaration that addresses anything in Dr. Hudson's declaration that you disagree with or found inappropriate?

MR. WILLIAMS: You're talking about the entire declaration one through six of part A and seven through eight of -- actually seven through nine of part B?

MR. GANNAM: I'm sorry?

MR. WILLIAMS: I want to make sure that I understand the question.

MR. GANNAM: Will you read my question back?

(The Court Reporter is directed to read back the previous question and/or answer.)

THE WITNESS: Perhaps you'd read number nine?

MR. WILLIAMS: Let her do this, Doctor. And let me ask.

MR. GANNAM: All right. Let me start with that question.

MR. WILLIAMS: Well, let me ask you a question, because his reference to Dr. Hudson is

specifically in paragraph Roman numeral 2A1. And my question is are you referring to just the six -- two through six thereafter or are you talking about B as well or anything before that? You said "in your declaration."

MR. GANNAM: All right. I'll ask --

MR. WILLIAMS: I want to make sure that I'm understanding.

MR. GANNAM: I'll ask the question. And if there's an objection, then make it. And we'll see if he can answer me.

MR. WILLIAMS: Okay. Fair enough.

BY MR. GANNAM:

Q Dr. Spack.

A Yes.

Q Have you now told me everything in your declaration that addresses a disagreement with Dr. Hudson's declaration or something in his declaration that you found inappropriate?

A Well, this may be redundant, but it is my concluding point, number nine. [As read]: There's no evidence-based support for treatments that attempt to change a young person's gender identity or gender expression. Conversion therapy deviates from the standards of care and guidelines promulgated for the

psychological and medical treatment of gender diverse adolescence.

MR. WILLIAMS: My objection, which I didn't get a chance to lodge, is the declaration speaks for itself. And I think the court can make its own conclusions as to what all this means. So I think it's unfair to the witness to ask him that kind of a question. He's answered the question. And then we'll go from there; okay?

BY MR. GANNAM:

Q Your attorney said you've answered the question. I want to let you have the last word on that. Have you now told me everything in your declaration that addresses anything you disagree with in Dr. Hudson's declaration or anything you found inappropriate in his declaration?

A I'm satisfied that my opinions have been heard.

Q All right. Let me take a break with my colleague for a moment and we will reconvene.

(A brief recess is had from 3:52 p.m. to 4:00 p.m.)

BY MR. GANNAM:

Q Just to clean up our record a little bit, I'm going to show you what was previously marked as

Exhibit 4. This is the Tampa ordinance 2017-47.

MR. WILLIAMS: Do I have a copy of that?

MR. GANNAM: We marked it as 4 during one of the earliest depositions.

MR. WILLIAMS: Right. Right. Give me a second.

BY MR. GANNAM:

Q Dr. Spack, is this in fact the ordinance that we've been talking about --

A Yes.

Q -- in this case?

Great. And have you had a chance to read this ordinance before?

A I did, yes.

Q Okay. And does your reading it include all those various "whereas" clauses leading up the text of the ordinance?

A I never saw so many whereases in my life.

Q Great. All right. I have no further questions.

CROSS EXAMINATION

BY MR. WILLIAMS:

Q All right. Dr. Spack, I just want to clarify some things in my mind. Mr. Gannam went over your declaration, which is Exhibit 36 to your deposition that

you signed on June 12th, 2019. And you have that in front of you there, don't you?

A Yes.

Q He also talked about the 2015 guidelines. Do you remember that part of his --

A Yes.

Q -- question?

2015 APA guidelines, I think.

MR. GANNAM: You want to give the Exhibit number, just for the record?

MR. WILLIAMS: Yeah. You're better at that than I am. I didn't have a copy of that.

MR. GANNAM: 33.

MR. WILLIAMS: May I borrow your copy?

MR. GANNAM: Why don't you borrow his copy because all the pictures I drew of you in the margin on this one.

MR. WILLIAMS: I'm sure they're pretty pictures.

BY MR. WILLIAMS:

Q If you don't mind, I'll borrow that.

So Exhibit 33 is the American Psychological Association 2015 guidelines.

Now, Doctor, with those -- with your declaration in mind and the APA guidelines in mind,

first of all, let me ask you, you've now been through the better part of the day under Mr. Gannam's grilling -- questioning.

MR. MIHET: Skillful.

MR. WILLIAMS: Skillful. Yes. Skillful and adroit.

BY MR. WILLIAMS:

Q But grilling, nevertheless. Has anything that Mr. Gannam has introduced to you today caused you to change in your mind -- well, any of your statements in your declaration?

MR. GANNAM: Objection, leading.

You can answer.

THE WITNESS: There was -- I'm not sure if it's in here or -- there was a place where the two options.

BY MR. WILLIAMS:

Q Yeah. I'm talking about -- I think you talked about in connection with this. But are the statements that you made in your declaration signed in June still valid statements, as far as you know?

A Yes.

MR. GANNAM: I just want to object, asked and answered.

BY MR. WILLIAMS:

Q Now, you just mentioned the two options. And I remember that. And Mr. Gannam asked you -- I think the question was, talked about two options. What options did you understand him to be talking to you about -- asking you about?

A It relate -- I don't even remember which document it was. But it --

Q I believe it was connected with 33.

MR. GANNAM: Objection, leading.

MR. WILLIAMS: That's true.

THE WITNESS: And the issue was whether or not in response to the statement of two approaches to the treatment of children who had gender dysphoria, whether I had -- whether I had said they were equal or not.

MR. GANNAM: I didn't ask that question, so...

BY MR. WILLIAMS:

Q Well, I'll ask it. Are they equal?

A Not necessarily. And the reason is that -- well, could I just look at it again?

Q Sure. Here's the '15 -- or '15 guidelines. Here's your declaration.

MR. GANNAM: I just want to object to the record of leading the witness to a document.

MR. MIHET: For the record, Attorney Minter is

now flipping through the exhibit and has opened it to a particular paragraph and pointed the witness to it.

MR. MINTER: Yes. The same paragraph that he was questioned about earlier.

MR. WILLIAMS: And to save time, I might add. It's after 4:00.

THE WITNESS: Okay. I believe it was related to guideline eight on page 841 of the American Psychological Association.

And I'll read it. This is longer than I thought. Can I ask a question?

BY MR. WILLIAMS:

Q No, you can't. You can take whatever time you need to.

A [As read]: Many children develop stability in the gender identity between ages three and four, although gender consistency, which is recognition that gender remains the same across situations, often does not occur until ages four to seven. Children who demonstrate gender nonconformity in preschool and early elementary school may not follow this trajectory.

This comes from Zucker.

[As read]: Existing research suggests that 12 to 50 percent of all children diagnosed with gender

dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood.

The point here is that what Zucker says shouldn't be regarded as equivalent or shouldn't be regarded as the Bible from Sinai.

And I say this because he not only says things like this in 15 -- you know, like 15 personal references in a paragraph, but what he has said has been regarded as truth for a very long time, even in the pediatric endocrine community and in the pediatric psychological community. And if his solution or recommendation is put at equal weight with another, my only recommendation is look very carefully at the other because it's very likely to be more correct. And it's also very likely that when it was raised as a question or a -- or a letter to the editor or whatever, criticizing Zucker, it would have been shouted down. It's really a classic example of what -- of what happens when scientific -- a scientific approach becomes political.

Q Of the two choices, is one of them then the Zucker approach? Is that what you're saying?

A There is one Zucker approach here.

Q And is that the standard of care today, now?

A No more.

Q What is the standard of care? How would you identify that?

A Well --

Q The other approach?

A Yes. There are two standards of care about how to deal with the prepubertal kid who acts in a cross-gender way.

Zucker's approach was to isolate the child, limit the child to their own room, and not permit the child to play with any toys or anything reflecting their cross-gender feelings in another room in the house, as if -- what Zucker was trying to do was accept the possibility the kid may be gay, but try to keep the kid from being transgender.

The other example is the best example by Diane Ehrensaft of the University of California or San Francisco, whose attitude is follow the child's lead, you will have a happy child and you won't be making the child transgender in so doing because many kids change anyway. But you can make yourself a really miserable child if you follow Ken Zucker's approach.

Q Which of those two is now the standard of care?

A I think Ehrensaft is.

MR. GANNAM: Just I'm going to object to

assumes facts not in evidence.

MR. WILLIAMS: All right. I think I've covered those. Okay. Good enough. That's all I have.

MR. GANNAM: All right. Just for the record, I'll move to strike the cross-examination as beyond the scope of direct. And we have no follow-up.

MR. WILLIAMS: I move to strike your motion to strike.

MR. MIHET: And also as leading the witness, coaching, and improperly getting the witness to change their sworn testimony.

MR. WILLIAMS: I take offense to all the above objections because that's not what happened at all. All right. We're done?

Doctor, you have the right to read your transcript. I'm sure it will be transcribed. And I will -- if you want me to, I will send you, or the court reporter will send you a copy of your transcript. You have the right to read it, make any changes you want to, or whatever, or you can waive that. My advice is never waive that right. That's what I tell everybody, so...

MR. MIHET: We disagree that the witness has the right to make any changes that he wants to.

MR. WILLIAMS: Good God, how can you disagree with that. Hold on, Harry. I want to put you to a real test here.

(Off the stenographic record.)

COURT REPORTER: So Mr. Williams, you're getting a copy of the transcript, then?

MR. WILLIAMS: I'm sure they're going to order it and I'll take a copy. I'm assuming. Maybe I shouldn't assume. You guys going to order it?

MR. MIHET: Yes.

MR. WILLIAMS: That's what I thought.

(The reading and signing of the deposition is not waived.)

(At 4:13 p.m. the deposition was concluded.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, the undersigned authority, certify that NORMAN SPACK, M.D. personally appeared before me and was duly sworn.

WITNESS my hand this 15th day of August, 2019.

DAWN A. HILLIER, RMR, CRR, CLR
Notary Public - State of Florida
My Commission No.: GG 259309
Expires: 12-15-2022

CERTIFICATE

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, DAWN A. HILLIER, RMR, CRR, CLR certify that I was authorized to and did stenographically report the deposition of NORMAN SPACK, M.D.; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

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

DATED this 15th day of August, 2019.

DAWN A. HILLIER, RMR, CRR, CLR