EXHIBIT B

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

* * * * * * * *

B.P.J., by her next friend and	*	
Mother, HEATHER JACKSON,	*	
Plaintiff	*	Case No.
vs.	*	2:21-CV-00316
WEST VIRGINIA STATE BOARD OF	*	
EDUCATION, HARRISON COUNTY	*	
BOARD OF EDUCATION, WEST	*	
VIRGINIA SECONDARY SCHOOL	*	
ACTIVITIES COMMISSION, W.	*	
CLAYTON BURCH in his official	*	CONFIDENTIAL
Capacity as State Superintendent,	*	VIDEOTAPED
DORA STUTLER in her official	*	VIDEOCONFERENCE
Capacity as Harrison County	*	DEPOSITION
Superintendent, PATRICK MORRISEY	*	OF
In his official capacity as	*	GERALD MONTANO, D.O.
Attorney General, and THE STATE	*	February 24, 2022
OF WEST VIRGINIA,	*	
Defendants	*	

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1 CONFIDENTIAL VIDEOTAPED VIDEOCONFERENCE DEPOSITION
2 OF
3 GERALD MONTANO, D.O., taken on behalf of the Defendant,
4 State of West Virginia herein, pursuant to the Rules of
5 Civil Procedure, taken before me, the undersigned, Lacey
6 C. Scott, a Court Reporter and Notary Public in and for
7 the State of West Virginia, on Thursday, February 24,
8 2022, beginning at 10:06 a.m.
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1 A P P E A R A N C E S
2
3 JOSHUA BLOCK, ESQUIRE
4 American Civil Liberties Union Foundation
5 125 Broad Street
6 New York, NY 10004
7 COUNSEL FOR PLAINTIFF
8
9 KATHLEEN R. HARTNETT, ESQUIRE
10 ANDREW BARR, ESQUIRE
11 ZOE HELSTROM, ESQUIRE
12 KATELYN KANG, ESQUIRE
13 Cooley, LLP
14 3 Embarcadero Center, 20th Floor
15 San Francisco, CA 94111-4004
16 COUNSELS FOR PLAINTIFF
17
18 SRUTI SWAMINATHAN, ESQUIRE
19 Lambda Legal
20 120 Wall Street, 19th Floor
21 New York, NY 10005-3919
22 COUNSEL FOR PLAINTIFF
23
24

1 A P P E A R A N C E S (cont'd)
2
3 DAVID TRYON, ESQUIRE
4 CURTIS R.A. CAPEHART, ESQUIRE
5 State Capitol Complex
6 Building 1, Room E-26
7 Charleston, WV 25305
8 COUNSEL FOR STATE OF WEST VIRGINIA
9
10 ROBERTA F. GREEN, ESQUIRE
11 Shuman McCuskey Slicer, PLLC
12 1411 Virginia Street East
13 Suite 200
14 Charleston, WV 25301
15 COUNSEL FOR WEST VIRGINIA SECONDARY SCHOOL
16 ACTIVITIES COMMISSION
17
18 JEFFREY M. CROPP, ESQUIRE
19 Steptoe & Johnson
20 400 White Oaks Boulevard
21 Bridgeport, WV 26330
22 COUNSEL FOR HARRISON COUNTY BOARD OF EDUCATION and
23 HARRISON COUNTY SUPERINTENDENT DORA STUTLER
24

1 A P P E A R A N C E S (cont'd)
2
3 KELLY C. MORGAN, ESQUIRE
4 KRISTEN V. HAMMOND, ESQUIRE
5 Bailey Wyant
6 500 Virginia Street East
7 Suite 600
8 Charleston, WV 25301
9 COUNSEL FOR WEST VIRGINIA BOARD OF EDUCATION and
10 SUPERINTENDANT W. CLAYTON BURCH
11
12 CHRISTIANA HOLCOMB, ESQUIRE
13 Alliance Defending Freedom
14 15100 North 90th Street
15 Scottsdale, AZ 85260
16 COUNSEL FOR INTERVENOR, LAINEY ARMISTEAD
17
18 TIMOTHY D. DUCAR, ESQUIRE
19 Law Office of Timothy D. Ducar
20 7430 East Butherus Drive, Suite E
21 Scottsdale, AZ 85260
22 COUNSEL FOR INTERVENOR, LAINEY ARMISTEAD
23
24

1 A P P E A R A N C E S (cont'd)
2
3 RONALD G. JONES, ESQUIRE
4 Jackson Kelly, PLLC
5 501 Grant Street, Suite 1010
6 The Union Trust Building
7 Pittsburgh, PA 15219
8 COUNSEL FOR GERALD MONTANO, D.O.
9
10
11
12
13
14
15
16
17
18
19
20
21
22
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24

1 I N D E X
2
3 DISCUSSION AMONG PARTIES 10 - 14
4 WITNESS: GERALD MONTANO, D.O.
5 EXAMINATION
6 By Attorney Tryon 14 - 159
7 DISCUSSION AMONG PARTIES 159 - 161
8 CERTIFICATE 162
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

1 EXHIBIT PAGE
2
3 PAGE
4 NUMBER DESCRIPTION IDENTIFIED
5 4 Adolescent Medicine Evaluation --
6 5 Discharge Summary --
7 6 Outpatient Evaluations --
8 7 Outpatient Evaluations --
9 8 Adolescent Medicine Evaluation --
10 9 Progress Note --
11 11A Progress Note --
12 11B Progress Note --
13 33 Standards of Care for Health of
14 Transexual, and Gender
15 Nonconforming People --
16 36 Adolescent Medicine Questionnaire --
17 37 Doctor Note --
18 38 Doctor Note --
19 39 Doctor Note --
20 40 Procedure Note --
21 42 Doctor Note --
22 43 Doctor Note --
23 45 Confidential Disclosure Statement --
24

1 OBJECTION PAGE
2
3 ATTORNEY PAGE
4 Block 18, 21, 27, 27, 35, 38, 39, 40, 41, 45, 47, 49,
5 58, 59, 59, 60, 62, 62, 65, 65, 68, 68, 73, 76, 76, 77,
6 78, 86, 94, 95, 95, 95, 97. 99, 99, 99, 108, 119, 149,
7 155
8
9 Jones 20, 21, 25, 27, 38, 39, 40, 41, 45, 46, 48, 49,
10 50, 51, 51, 53, 57, 57, 58, 59, 60, 60, 61, 62, 63, 64,
11 65, 66, 68, 68, 68, 72, 73, 73, 74, 76, 76, 76, 76, 77,
12 77, 78, 78, 85, 86, 88, 89, 89, 90, 91, 93, 94, 94, 95,
13 95, 95, 97, 99, 99, 109, 116, 117, 120, 120, 121, 121,
14 125, 126, 129, 131, 137, 141, 141, 142, 143, 146, 147,
15 148, 149, 151, 152, 155, 156
16
17
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Page 10

1 STIPULATION
2 ---
3 (It is hereby stipulated and agreed by and between
4 counsel for the respective parties that reading,
5 signing, sealing, certification and filing are not
6 waived.)
7 ---
8 PROCEEDINGS
9 ---
10 VIDEOGRAPHER: We're now on the record.
11 My name is Jacob Stock. I'm a Certified Legal Video
12 Specialist employed by Sargent's Court Reporting
13 Services. The date today is February 24th, 2022. The
14 current time reads 10:06 a.m. This deposition is being
15 taken remotely by video conference. The caption of this
16 case is in the the United States District Court for the
17 Southern District of West Virginia, Charleston Division.
18 BPJ by her next friend and mother, Heather Jackson,
19 versus West Virginia State Board of Education, et al.
20 Case number 2:21-CV-00316. The name of the witness is
21 Gerald Montano, D.O. Will the attorneys present state
22 their names and the parties they represent?
23 ATTORNEY TRYON: This is David Tryon
24 representing the State of West Virginia. Curtis

Page 11

1 Capehart, my colleague, is also on the line.
2 ATTORNEY BLOCK: This is Josh Block,
3 representing the Plaintiff. And I have other colleagues
4 on the line that will identify themselves.
5 ATTORNEY SWAMINATHAN: This is Sruti
6 Swaminathan from Lambda Legal representing the
7 Plaintiff.
8 ATTORNEY HARTNETT:
9 This is Kathleen Hartnett from Cooley
10 representing the Plaintiff.
11 ATTORNEY KANG: This is Katelyn Kang from
12 Cooley representing Plaintiff.
13 ATTORNEY JONES: This is Ron Jones
14 representing Doctor Montano.
15 ATTORNEY CROPP: My name is Jeffrey Cropp
16 of Steptoe & Johnson, representing Defendants Harrison
17 County Board of Education and Dora Stutler.
18 ATTORNEY HELSTROM: This is Zoe Helstrom
19 from Cooley LLP representing the Plaintiff.
20 ATTORNEY DUCAR: This is Timothy Ducar on
21 behalf of the intervenor. Also on the line is my
22 colleague, Christiana Holcomb. I'd like to note that I
23 am viewing the real time transcript and the intervenor
24 is not going to participate in the charges for that.

Page 12

1 ATTORNEY MORGAN: This is Kelly Morgan on
2 behalf of the West Virginia Board of Education and
3 Superintendent Burch. Also on phone is Kristen Hammond
4 with my office as well. We do not need the real time or
5 a rough copy.
6 ATTORNEY GREEN: This is Roberta Green
7 here on behalf of West Virginia Secondary School
8 Activities Commission. We do not need the real time
9 feed nor do we want the rough copy of the transcript.
10 ATTORNEY DUCAR: This is Tim Ducar once
11 again. I didn't --- I didn't talk about the rough
12 draft, and we don't need that as well.
13 ATTORNEY BLOCK: This is Josh Block for
14 Plaintiff again. We don't need the real time either.
15 VIDEOGRAPHER: And if that's everybody,
16 the court reporter can swear in the witness and we can
17 begin.
18 ATTORNEY BARR: Sorry, this is Andrew
19 Barr for the Plaintiff. I got kicked out of the room
20 and just reentered. I'm with Cooley L.L.P.
21 VIDEOGRAPHER: Okay.
22 ---
23 GERALD MONTANO, D.O.,
24 CALLED AS A WITNESS IN THE FOLLOWING PROCEEDING, AND

Page 13

1 HAVING FIRST BEEN DULY SWORN, TESTIFIED AND SAID AS
2 FOLLOWS:
3 ---
4 ATTORNEY TRYON: Thank you. Before we
5 actually get started, I was on muted --- I was mute ---
6 muted, so I meant to say there is a couple things we
7 wanted to hit right before we actually get started with
8 regard to how we're handling objections. I think we can
9 do that with the witness present and in discussion with
10 Mr. Jones prior to this. And as we have done in prior
11 depositions to make things smoothly, these are the ---
12 what I would like to propose as far as how objections
13 are handled. That the objections would be limited to
14 objections to form, objections to scope, specifically as
15 to that this doctor is not going to serve as an expert
16 witness and objections to terminology since we have
17 various terminology that each party prefers to use and
18 objections for privilege if the witness's counsel needs
19 to assert that. Is that satisfactory to you, Mr. Block?
20 ATTORNEY BLOCK: Yes, it is.
21 ATTORNEY TRYON: And Mr. Jones, that's
22 satisfactory to you.
23 ATTORNEY JONES: Yes, it is.
24 ATTORNEY TRYON: And Mr. Jones, for some

1 reason your picture is frozen for me. That's okay, but
2 just FYI for your information. Does anybody else have
3 any objection to that procedure? Okay. Then we will go
4 ahead and move forward.
5 ---
6 EXAMINATION
7 ---
8 BY ATTORNEY TRYON:
9 **Q. Mr. Montano, thank you very much for joining me**
10 **this morning. I appreciate your time, I know your time**
11 **is valuable. And I will try to make this as smooth and**
12 **move through this as quickly as possible. So thank you**
13 **again?**
14 A. You're welcome.
15 **Q. First of all, who's there with you for the**
16 **record?**
17 A. Ron Jones. I'm sorry, my lawyer.
18 **Q. And you are represented by counsel?**
19 A. Yes.
20 **Q. And who is that?**
21 A. Ron Jones.
22 **Q. Have you ever been deposed before?**
23 A. Yes.
24 **Q. Tell me about that. What case was that in?**

1 A. It was regarding a case of whether or not to
2 allow one of my patients to proceed with
3 gender-affirming hormones because their parents
4 objected.
5 **Q. When was that?**
6 A. I recall 2018.
7 **Q. And were you sued in that case?**
8 A. No.
9 **Q. Who was suing whom?**
10 A. It wasn't a lawsuit, it was trying to determine
11 if this kid needed care, and I served as a witness.
12 **Q. You served as an expert witness?**
13 A. No, witness to that person's care.
14 **Q. And what was the result of that?**
15 A. The patient was allowed to get on
16 gender-affirming hormones.
17 **Q. What hormones were those?**
18 A. Testosterone.
19 **Q. So that was a female who wanted to take**
20 **testosterone.**
21 **Is that right?**
22 A. Can you repeat?
23 **Q. Yes.**
24 A. Can you repeat the question?

1 **Q. Yes, that was someone who --- a female that**
2 **wanted to take testosterone?**
3 A. It was a --- someone who was assigned a female
4 at birth who identified as male.
5 **Q. Have you been deposed any other times besides**
6 **that?**
7 A. No.
8 **Q. Have you ever been sued?**
9 A. No.
10 **Q. Have you ever testified at trial?**
11 A. No.
12 **Q. So as we go through here, just for everyone's**
13 **reference, we're in Federal Court, so the Federal Rules**
14 **of Civil Procedure apply here. And Federal Rules of**
15 **Civil Procedure 30(c)(2) regarding objections says that**
16 **an objection at the time of examination, whether to**
17 **evidence to party's conduct or to the officer's**
18 **qualifications, to the manner of taking deposition or to**
19 **any other aspect of the deposition must be noted on the**
20 **record, but the examination still proceeds. And we**
21 **discussed how we're going to do objections.**
22 **And Mr. Montano --- Doctor Montano, if your**
23 **counsel or any other lawyer objects, then you are still**
24 **required to answer unless instructed not to by your**

1 **lawyer.**
2 **Do you understand that?**
3 A. Yes.
4 **Q. And I would ask you to make sure that you answer**
5 **verbally as opposed to nodding or shaking your head for**
6 **the court reporter's benefit.**
7 **Okay?**
8 A. Yes.
9 **Q. And if you don't understand a question, please**
10 **tell me and I will try and clarify my question. And if**
11 **you answer the question, that indicates to me that you**
12 **do understand the question.**
13 **So do you understand that?**
14 A. Yes.
15 **Q. And finally, if you need a break, let me know**
16 **and we will do our best to break for you. And the only**
17 **qualifications on that is that we can't take a break**
18 **while a question is pending.**
19 **All right?**
20 A. Yes.
21 **Q. So are you familiar with the subject of the**
22 **lawsuit that we're here for?**
23 A. Yes.
24 **Q. Are you familiar with the law that's involved,**

1 **commonly known as by some of us as Save Women's Sports**
2 **Act, also known as HB 3293?**
3 A. Yes.
4 **Q. Are you aware of who BPJ is?**
5 A. Yes.
6 **Q. What is your understanding of who BPJ is?**
7 A. She is the Plaintiff of that case.
8 **Q. Has BPJ been your client in the past?**
9 A. Yes.
10 **Q. Does BPJ continue to be your patient?**
11 A. No.
12 **Q. Do you know BPJ's full name?**
13 A. Yes.
14 **Q. Okay.**
15 **I understand there's some concern about using a**
16 **child's birth name in these circumstances, but can you**
17 **give me the full name as you understand it to be?**
18 ATTORNEY BLOCK: Objection. Do you mean
19 --- do you want the name assigned at birth or do you
20 want the name that BPJ goes by?
21 BY ATTORNEY TRYON:
22 **Q. Give me the name that you use for BPJ?**
23 A. B[redacted] P[redacted]r-J[redacted]
24 **Q. But you're aware of the birth name.**

1 **Correct?**
2 A. Yes.
3 **Q. Have you brought any documents to the deposition**
4 **today?**
5 A. Yes.
6 **Q. What documents have you brought?**
7 A. I brought medical records and also the
8 psychosocial assessment.
9 ATTORNEY JONES: Just for the record,
10 this is Ron Jones, these are the records that were
11 provided.
12 ATTORNEY TRYON: I'm sorry. I didn't
13 hear you, Mr. Jones.
14 ATTORNEY JONES: I'm sorry. Can you hear
15 me now?
16 ATTORNEY TRYON: Yes.
17 ATTORNEY JONES: I said just for the
18 record these were the records that were provided by
19 counsel.
20 ATTORNEY TRYON: Okay.
21 ATTORNEY JONES: Based on the nature that
22 this is a virtual deposition.
23 BY ATTORNEY TRYON:
24 **Q. So the medical records that we have seen have**

1 **your name on them and --- on many of them and some of**
2 **them say that you edited them or reviewed them or that**
3 **you were the author. Is that a typical process?**
4 A. Yes.
5 **Q. And if it says that you were --- that you either**
6 **edited them or reviewed them or that you were the**
7 **author, is it safe to rely upon the accuracy of those**
8 **statements that you did so?**
9 A. Yes.
10 **Q. And when did you last review the documents that**
11 **you have --- let me rephrase that. When is the last**
12 **time you reviewed the medical records for BPJ?**
13 A. This morning.
14 **Q. Have you gone through what you believed to be**
15 **all of the medical records for BPJ from your offices?**
16 A. Yes.
17 **Q. Are they correct?**
18 ATTORNEY JONES: Objection to form. You
19 can answer.
20 THE WITNESS: Yes.
21 BY ATTORNEY TRYON:
22 **Q. Is there anything you saw that's incorrect that**
23 **you need to correct before we review them.**
24 ATTORNEY JONES: Objection to form. You

1 can answer.
2 THE WITNESS: Can you repeat the question
3 again?
4 BY ATTORNEY TRYON:
5 **Q. Yes. Did you see anything in there during the**
6 **review that you believe is incorrect that you need to**
7 **correct before we review them?**
8 A. No.
9 **Q. Have you had any type of communications, whether**
10 **written or oral, with BPJ's lawyers?**
11 A. Yes.
12 **Q. When was the first time that you did?**
13 A. I don't recall the exact date, but I believe it
14 was early January.
15 **Q. Do you remember who you spoke with? Let me**
16 **rephrase that. What type of communication was it?**
17 A. It was a phone call.
18 **Q. Who was it with?**
19 A. Avatara Smith-Carrington.
20 **Q. And who initiated that phone call?**
21 A. Avatara or Ms. Smith Carrington.
22 ATTORNEY BLOCK: Just objection. Avatara
23 uses they/them pronouns.
24 THE WITNESS: Thank you.

Page 22

1 BY ATTORNEY TRYON:
2 **Q. What was discussed?**
3 A. What was discussed was that the lawyers from
4 West Virginia intended to depose me as a witness to
5 BPJ's case.
6 **Q. So what else was discussed? Tell me about the**
7 **details of that conversation.**
8 A. They just summarized what was the nature of the
9 case and why they --- why the lawyers from West Virginia
10 wanted to talk to me about it.
11 **Q. What did you tell Avatara?**
12 A. I just said that, okay, what would I expect
13 next.
14 **Q. What were you told to expect?**
15 A. That they will contact me and request a
16 deposition and that's all that I recall.
17 **Q. Did they --- did ---?**
18 ATTORNEY TRYON: I'm sorry. Josh, what
19 is the first name again. Avatara?
20 ATTORNEY BLOCK: Avatara.
21 ATTORNEY TRYON: Can you spell that for
22 me?
23 ATTORNEY BLOCK: Yes, A-V-A-T-A-R-A.
24 ATTORNEY TRYON: Thank you.

Page 23

1 BY ATTORNEY TRYON:
2 **Q. Did Avatara tell you what you should say in the**
3 **deposition?**
4 A. No.
5 **Q. Any other communications with Plaintiff's**
6 **attorneys?**
7 A. With --- if I can --- Sruti Swaminathan
8 regarding medical records.
9 **Q. When was that?**
10 A. As I recall, the end of January.
11 **Q. Was it a phone call or other communication?**
12 A. Phone call.
13 **Q. What happened in that phone call?**
14 A. Sruti asked about certain medical records and
15 where he can get them, and I directed her to the
16 Department that handles medical records.
17 **Q. Anything else?**
18 A. No.
19 **Q. Any other communications?**
20 A. None.
21 **Q. So only two communications with Plaintiff's**
22 **counsel?**
23 A. Yes.
24 **Q. Do you know a Doctor Kacie Kidd?**

Page 24

1 A. Yes.
2 **Q. How do you know Doctor Kidd?**
3 A. I am one of her mentors when she was a fellow.
4 **Q. What does that mean to be a mentor?**
5 A. It means being an advisor on academic and career
6 advancement.
7 **Q. When is the last time you had any communications**
8 **with Doctor Kidd?**
9 A. As I recall, two weeks ago.
10 **Q. What was that communication?**
11 A. Can you rephrase the question?
12 **Q. Did you have a phone call or a written**
13 **communication with Doctor Kidd two weeks ago?**
14 A. Phone call.
15 **Q. And what was the subject of that phone call?**
16 A. How stressed we were about this case.
17 **Q. And who called whom?**
18 A. As I recall, she called me.
19 **Q. What else was discussed besides the fact that**
20 **you were both stressed about the case?**
21 A. That was all.
22 **Q. Was that before or after her deposition?**
23 A. I don't recall.
24 **Q. Did she tell you anything about her deposition?**

Page 25

1 A. No.
2 **Q. Why was she stressed about this case?**
3 A. I think any physician being disposed (sic) can
4 be stressful.
5 **Q. And you said you were also stressed about this**
6 **case?**
7 A. Yes.
8 **Q. And why is that?**
9 A. Again, any physician who's deposed, it's always
10 a stressful experience.
11 **Q. Well, I will try to not to make this stressful**
12 **for you. I'll try and do my best to give you**
13 **straightforward questions. Anything else that was**
14 **discussed in that conversation?**
15 A. No.
16 **Q. Any other communications with Doctor Kidd in the**
17 **past two weeks?**
18 ATTORNEY JONES: Objection to form.
19 Regarding this matter?
20 ATTORNEY TRYON: Yes regarding this
21 matter.
22 THE WITNESS: None.
23 BY ATTORNEY TRYON:
24 **Q. So there's some things I want to understand that**

Page 26

1 **I have read during the course of this case that I think**
2 **you may have had some involvement with. So do you know**
3 **what a ████ █████ is?**
4 A. Yes.
5 **Q. And can you tell me what that is?**
6 A. It is a form of pubertal blocker.
7 **Q. What chemical is in a ████ implant?**
8 A. The general term would be a
9 gonadotropin-releasing hormone agonist.
10 **Q. I think I've seen the term █████ What is**
11 **that?**
12 A. That is the generic term of the medication.
13 **Q. I understand that that's been FDA approved for**
14 **precocious puberty.**
15 **Is that right?**
16 A. Yes.
17 **Q. I have also seen that it is using it for a**
18 **puberty delay is an off-label use and is not FDA**
19 **approved.**
20 **Is that right?**
21 A. Can you be specific when you said not FDA
22 approved for which condition?
23 **Q. Sure. It is my understanding it is not FDA**
24 **approved just for puberty delay but only for precocious**

Page 27

1 **puberty.**
2 **Is that right?**
3 ATTORNEY BLOCK: Objection to form.
4 THE WITNESS: It is not FDA approved for
5 treating gender dysphoria.
6 BY ATTORNEY TRYON:
7 **Q. What is the significance of that?**
8 ATTORNEY JONES: Objection to form.
9 THE WITNESS: I don't understand the
10 question. Can you rephrase it?
11 ATTORNEY TRYON: I'll move on.
12 BY ATTORNEY TRYON:
13 **Q. How does Histrelin work? What does it do?**
14 A. So what it does, in simple terms, it blocks the
15 communication between the hypothalamus and the
16 pituitary. And what that ultimately does is that it
17 stops the gonads from producing either testosterone and
18 estrogen, which are important hormones in puberty
19 development.
20 **Q. And the ████ █████ itself is --- well, tell**
21 **me what that is.**
22 ATTORNEY BLOCK: Objection to form.
23 ATTORNEY TRYON: Go ahead.
24 THE WITNESS: Can you rephrase the

Page 28

1 question?
2 BY ATTORNEY TRYON:
3 **Q. The actual ████ █████ is similar to a stick.**
4 **Is that right?**
5 A. Yes.
6 **Q. Can you describe the diameter and the length?**
7 A. It's about four centimeters.
8 **Q. Long?**
9 A. Yes.
10 **Q. Right --- okay.**
11 **And how thick is it?**
12 A. I estimate around five millimeters.
13 **Q. And how long does it work?**
14 A. It is FDA approved for one year, but studies
15 show that it could be extended into two.
16 **Q. And how much does it cost?**
17 A. It depends. If it's the ████ brand, it's
18 about $4,000. The █████ brand is $40,000.
19 **Q. Did you say 4-0 thousand?**
20 A. That is correct.
21 **Q. I have also read about a Nexplanon implant.**
22 **What is that?**
23 A. That is a form of birth control.
24 **Q. What chemical is used in the Nexplanon implant?**

Page 29

1 A. Etonogestrel. And let me know if you want me to
2 spell that.
3 **Q. I've got it. And that's FDA approved for**
4 **contraception.**
5 **Is that right?**
6 A. Yes.
7 **Q. That's not used for puberty delay, is it?**
8 A. No.
9 **Q. So let me go back and get some basic**
10 **information. Give me your --- if you wouldn't mind**
11 **giving me your business address please?**
12 A. 120 Lytton, L-Y-T, as in Timothy, T as in
13 Timothy, O-N, as in Nancy, Suite M, as in Michael, 060,
14 Pittsburgh PA, 15213.
15 **Q. What is your business number?**
16 A. Can you rephrase the question?
17 **Q. Do you have a work number?**
18 A. As in a phone number?
19 **Q. Yes. Sorry.**
20 A. (412) 692-6356.
21 **Q. And I'm going to ask for your home number or**
22 **cell number, whichever is preferably, in the event that**
23 **for some reason you're not represented by counsel and we**
24 **need to get a hold of you. That would be only if your**

Page 30

1 **counsel is --- if you are no longer represented would I**
2 **ever use this number.**
3 A. Cell phone number?
4 **Q. Yes.**
5 A. [redacted]
6 **Q. So on your website it shows that you are Board**
7 **Certified with the American Board of Pediatrics in**
8 **Pediatrics and Adolescent Medicine.**
9 **Is that accurate?**
10 A. Yes.
11 **Q. And when did you get that Board Certification?**
12 A. Can you clarify which one?
13 **Q. Oh, it's more than one?**
14 A. Yes.
15 **Q. Let's start with pediatrics.**
16 A. 2013.
17 **Q. And Adolescent Medicine?**
18 A. 2020.
19 **Q. What does it take to get Board Certification in**
20 **Pediatrics?**
21 A. You are required to go to medical school and
22 graduate and then you have to complete a three-year
23 residency in pediatrics in order to sit for the Boards.
24 **Q. Anything else?**

Page 31

1 A. Passing the exam.
2 **Q. And then for Adolescent Medicine, what do you**
3 **have to do for that?**
4 A. Not only do you have to go through or complete a
5 pediatric residency, you will need to complete an
6 adolescent medicine fellowship and a research project
7 during that time and then sit for the Boards and pass
8 it.
9 **Q. Is it a different set of Boards?**
10 A. Yes.
11 **Q. What is the significance of having a**
12 **certification in pediatrics?**
13 A. It verifies that you have the correct and
14 acceptable knowledge in your field.
15 **Q. Are there things that it enables you to do**
16 **professionally that otherwise you could not do?**
17 A. Technically you can practice without Board
18 Certification, but some hospitals will not allow you to
19 practice in their facility if you are not Board
20 Certified or at least Board Eligible.
21 **Q. I also read that you are the Medical Director on**
22 **the Gender and Sexuality Development Program at UPMC**
23 **Children's Hospital of Pittsburgh.**
24 **Is that correct?**

Page 32

1 A. Yes.
2 **Q. When did you become that --- when did you get**
3 **that title?**
4 A. As I recall, I believe it was 2018.
5 **Q. What do you do in that position?**
6 A. So I create a program and work with several
7 colleagues in delivering gender-affirming care and
8 oversee to make sure that is done in a correct manner.
9 **Q. When you say you create a program, can you tell**
10 **me what that means?**
11 A. That means create --- gathering a group of
12 professionals in mental health, in pediatrics and
13 nursing and basically discussing and creating what kind
14 of services we can provide for our patients.
15 **Q. In that position do you supervise others?**
16 A. Yes.
17 **Q. How many people do you supervise?**
18 A. Estimation currently, around nine people.
19 **Q. Do you see patients in that capacity?**
20 A. Yes.
21 **Q. And I read that you are also an Assistant**
22 **Professor of pediatrics at the University of Pittsburgh**
23 **School of Medicine.**
24 **Is that correct?**

Page 33

1 A. Yes.
2 **Q. When did you take that position?**
3 A. That would be in 2017.
4 **Q. What do you do in that position?**
5 A. So I'm primarily responsible for the teaching of
6 our residents and assisting in research.
7 **Q. When you say teach residents, is this in a**
8 **classroom setting?**
9 A. No.
10 **Q. Tell me about it then.**
11 A. So I teach residents in terms of inside the
12 clinic and supervise their care of the patients there.
13 **Q. Tell me about the clinic.**
14 A. Can you be more specific?
15 **Q. All right. I will be. Trying to understand**
16 **what --- what this clinic is, where it is, what it does,**
17 **how many patients it has. Let's just start in general,**
18 **what does --- what's the name of the clinic?**
19 A. The Center for Adolescent and Young Adult
20 Health.
21 **Q. Where is it located?**
22 A. In the University Center at the same address as
23 where I work.
24 **Q. Are you employed by the Center for Adolescent**

1 **and Young Adult Health?**
2 A. No, I'm employed by University of Pittsburgh
3 Physicians.
4 **Q. But you work at the Center for Adolescent and**
5 **Young Adult Health?**
6 A. Yes.
7 **Q. I'm just going to call that the clinic from now**
8 **on. Does the clinic see patients there?**
9 A. Yes.
10 **Q. How many doctors see patients there?**
11 A. Counting how much ---?
12 **Q. Let me clarify my question. How many doctors**
13 **are there that see patients there?**
14 A. By my estimation, around eight.
15 ATTORNEY TRYON: So I hear somebody's
16 kids, I think.
17 BY ATTORNEY TRYON:
18 **Q. I don't know if that --- where that's at. Is**
19 **that where you're at Doctor Montano?**
20 A. No.
21 ATTORNEY BLOCK: They're mine. Sorry.
22 ATTORNEY TRYON: That's okay, Josh. I
23 was wondering if they were somewhere in my office. But
24 that's okay, Josh. You do what you got to do.

1 BY ATTORNEY TRYON:
2 **Q. So about how many patients come through there in**
3 **a week?**
4 A. I don't know.
5 **Q. Would it be 10, 20, 100?**
6 A. I don't know. I don't keep count of that.
7 **Q. What is the funding for the clinic --- let me**
8 **rephrase that. Where does the funding come from for the**
9 **clinic?**
10 ATTORNEY BLOCK: Objection, scope.
11 ATTORNEY TRYON: Go ahead. I'm just
12 trying to --- I'm just trying understand. Let me
13 actually ask a different question.
14 BY ATTORNEY TRYON:
15 **Q. Is the clinic separate or is it part of a larger**
16 **organization?**
17 A. It's part of a larger organizations.
18 **Q. Which is what?**
19 A. UPMC Children's Hospital of Pittsburgh.
20 **Q. Is that the only place where you see patients,**
21 **at the clinic, that is?**
22 A. No.
23 **Q. Where else do you see patients?**
24 A. At the Student Health Center at University of

1 Pittsburgh.
2 **Q. Any other place where you see patients?**
3 A. No.
4 **Q. On your website it says that you received your**
5 **medical degree from Kansas City University of Medicine**
6 **in bioscience.**
7 **Is that right?**
8 A. Yes.
9 **Q. And when was that?**
10 A. 2010.
11 **Q. And your master's degree in clinical research**
12 **from the University of Pittsburgh.**
13 **Is that right?**
14 A. Yes.
15 **Q. And when was that?**
16 A. 2016.
17 **Q. Is there a particular major or emphasis that you**
18 **had in your master's degree?**
19 A. Clinical research.
20 **Q. Okay.**
21 **And then it says that you completed a**
22 **pediatrics residency at Saint John Children's Hospital.**
23 **Is that right?**
24 A. Yes.

1 **Q. And when did you complete that residency?**
2 A. 2013.
3 **Q. And then your fellowship in adolescent medicine**
4 **at UPMC Children's Hospital, Pittsburgh.**
5 **Is that right?**
6 A. Yes.
7 **Q. What year was that?**
8 A. 2016.
9 **Q. And your post-doctoral research --- sorry. You**
10 **were a post-doctoral research scholar in primary care**
11 **research at the University of Pittsburgh.**
12 **Right?**
13 A. Yes.
14 **Q. When was that?**
15 A. From 2014 to 2016.
16 **Q. What does that mean to be a research scholar?**
17 A. You get training on how to conduct research
18 under supervision from a mentor.
19 **Q. On your website it says that your interests**
20 **include increasing healthcare access for transgender and**
21 **gender-diverse youth and advocating for government and**
22 **systems policies that protect and enhance their health**
23 **and wellbeing. Is that accurate as stated on your**
24 **website?**

1 A. Yes.
2 **Q. And what government policies do you advocate in**
3 **this context?**
4 A. Any government policies that would make any
5 transperson's environment a safe place to be.
6 **Q. Are there any specific government policies that**
7 **you have either advocated for or against?**
8 ATTORNEY JONES: Objection to form.
9 ATTORNEY BLOCK: Same.
10 THE WITNESS: Can you rephrase the
11 question?
12 BY ATTORNEY TRYON:
13 **Q. Sure. You indicate that one of your interests**
14 **is advocating for government policies that protect and**
15 **enhance the health and wellbeing of gender-diverse youth**
16 **and transgender youth. My question is have you actually**
17 **advocated for any particular government policies?**
18 A. For, no.
19 **Q. Against?**
20 A. Yes.
21 **Q. Did you advocate against HB 3293?**
22 A. No.
23 **Q. What government policies did you advocate**
24 **against?**

1 A. I don't recall the bill number, but it was a law
2 in Pennsylvania that would prevent transgender girls
3 from playing in women's sports.
4 **Q. What did you do --- excuse me. What did you do**
5 **to advocate against that law?**
6 ATTORNEY BLOCK: Objection to scope.
7 ATTORNEY JONES: Same.
8 THE WITNESS: Should I answer ---?
9 ATTORNEY JONES: If you understand the
10 question.
11 THE WITNESS: Yes, I understand the
12 question. I testified in the Pennsylvania Assembly.
13 BY ATTORNEY TRYON:
14 **Q. When was that?**
15 A. I believe August 2021.
16 **Q. Have you been asked to be an expert witness in**
17 **this case?**
18 A. Yes.
19 **Q. When were you asked to be an expert witness in**
20 **this case?**
21 A. Around August 2021.
22 **Q. Did you agree to be an expert witness in this**
23 **case?**
24 A. Yes.

1 ATTORNEY BLOCK: Objection to form.
2 BY ATTORNEY TRYON:
3 **Q. Do you anticipate submitting an expert report in**
4 **this case?**
5 A. No.
6 **Q. Why not?**
7 ATTORNEY JONES: Objection to form.
8 ATTORNEY TRYON: You can answer.
9 THE WITNESS: I wasn't requested to.
10 BY ATTORNEY TRYON:
11 **Q. Do you anticipate testifying as an expert in**
12 **this case?**
13 A. No.
14 **Q. And why not?**
15 A. I wasn't asked to.
16 **Q. Have you --- so I'm trying to understand this**
17 **because you said you agreed to be an expert witness in**
18 **this case, but you don't anticipate testifying. Has**
19 **that request been withdrawn?**
20 A. Just to be clear, which case are you referring
21 to?
22 **Q. Maybe we're confused. I'm talking the BPJ case.**
23 **Have you been asked --- let me start over then. Have**
24 **you been asked to testify --- sorry. Have you been**

1 **asked to serve as an expert witness in the BPJ case?**
2 ATTORNEY BLOCK: Objection to form.
3 ATTORNEY JONES: Same. You can answer.
4 THE WITNESS: No.
5 BY ATTORNEY TRYON:
6 **Q. Thank you. That's --- I was confused there. I**
7 **apologize if I caused that confusion.**
8 **I presume you're licensed to practice medicine.**
9 **Which states would you be --- are you licensed to**
10 **practice in?**
11 A. Pennsylvania.
12 **Q. Any others?**
13 A. No.
14 **Q. I understand you're a member of the American**
15 **Academy of Pediatrics.**
16 **Is that correct?**
17 A. Yes.
18 **Q. And what is the American Academy of Pediatrics?**
19 A. It is a professional organization of
20 pediatricians.
21 **Q. What does it take to be a member?**
22 A. You have to be a healthcare professional that
23 deals with pediatrics and you pay a fee to be a member.
24 **Q. Why did you join?**

1 A. It will help me network with other providers and
2 it's a good learning opportunity because they also offer
3 conferences.
4 **Q. Do you do anything else in there besides attend**
5 **conferences and network?**
6 A. No.
7 **Q. I understand you're also a member of the Society**
8 **for Adolescent Health and Medicine.**
9 **Is that right?**
10 A. Yes.
11 **Q. What is that?**
12 A. That is another professional organization and
13 they specialize or focus on the adolescents' and young
14 adults' health.
15 **Q. How is it different from the American Academy of**
16 **Pediatrics?**
17 A. Their focus. So in the AAP, the American
18 Academy of Pediatrics, they look at all pediatrics,
19 which include the age of 18, but in Society of
20 Adolescent Health and Medicine it could be anywhere
21 between 9 to 26-year-olds. So they have different laps
22 or different scopes.
23 **Q. What does it take to be a member of that?**
24 A. You have to be some sort of professional or

1 someone who has interest in adolescent and young adult
2 health and pay a membership fee.
3 **Q. You said professional. So that would include**
4 **any kind of professional or just medical professionals?**
5 A. It could be any serving professionals like
6 therapists or nurses.
7 **Q. Why did you join that one?**
8 A. Again, for networking opportunities, learning
9 opportunities, and camaraderie.
10 **Q. You are the Treasurer/Secretary for the Ohio**
11 **Valley Society of Adolescent Medicine. What is that?**
12 A. So that is a regional organization that is
13 focusing on the health of adolescent and young adult
14 health, but this time within the areas of southwestern
15 Pennsylvania, eastern Ohio, West Virginia and Kentucky,
16 basically the Ohio Valley area.
17 **Q. Are you a member of WPATH?**
18 A. No.
19 **Q. Why not?**
20 A. I have not had the chance to join.
21 **Q. Are you a member of any other organizations?**
22 A. That's about it.
23 **Q. Where do you currently work?**
24 A. At the Center for Adolescent Youth and Health.

1 **Q. Which is the clinic.**
2 **Right?**
3 A. Yes.
4 **Q. Where else do you work?**
5 A. The student health center at University of
6 Pittsburgh.
7 **Q. And where else?**
8 A. That's all.
9 **Q. So you are an assistant professor at the**
10 **University of Pittsburgh. Do you not work there?**
11 A. I will make a correction. I do work at the
12 University of Pittsburgh as well.
13 **Q. Any place else?**
14 A. That's all.
15 **Q. Okay.**
16 **And so you are currently a treating physician.**
17 **Right?**
18 A. Yes.
19 **Q. Tell me about the areas of your medical**
20 **practice.**
21 A. Can you rephrase the question?
22 **Q. Sure. I mean, I can kind of infer that you ---**
23 **your medical practice is for adolescents and youth and**
24 **children. Would that much be accurate?**

1 A. Yes.
2 **Q. Is it beyond that? Do you treat or diagnose**
3 **adults?**
4 A. I treat young adults.
5 **Q. So what age group or age range of people do you**
6 **treat?**
7 A. Anywhere between 9 to up to 26 years old.
8 **Q. What types of medical issues or problems**
9 **diseases, disorders, do you see the most?**
10 ATTORNEY BLOCK: Objection to form.
11 ATTORNEY JONES: Same.
12 THE WITNESS: Can you rephrase the
13 question?
14 BY ATTORNEY TRYON:
15 **Q. I'm trying to understand the scope of your**
16 **practice. Is it just --- is it anything that 9 to**
17 **26-year-olds encounter or do you limit your practice?**
18 A. I don't limit my practice, so yes, I see many of
19 the medical issues for anyone between 9 to 26 years old.
20 **Q. So do you treat people for cold, flu, ear**
21 **infections, those types of things?**
22 A. Yes.
23 **Q. And mental health issues?**
24 A. Yes.

Page 46

1 **Q. Would that include bipolar issues?**
2 A. No.
3 **Q. How about chronic depression?**
4 A. Yes.
5 **Q. How about things like bulimia?**
6 A. Yes.
7 **Q. Borderline personality disorder?**
8 A. Yes.
9 **Q. Urinary tract infection?**
10 A. Yes.
11 **Q. Gender dysphoria?**
12 A. Yes.
13 **Q. How much of your time is spent on --- as a**
14 **treating physician versus other parts of your**
15 **professional work?**
16 A. I would say about 80 percent.
17 **Q. And that 80 percent, would that include**
18 **supervising other doctors or is that separate?**
19 A. It includes supervising other doctors.
20 **Q. When patients come to you they sometimes**
21 **probably already have a self diagnosis or what they**
22 **think they have.**
23 **Is that right?**
24 ATTORNEY JONES: Objection to form.

Page 47

1 THE WITNESS: Can you rephrase the
2 question? I don't understand.
3 BY ATTORNEY TRYON:
4 **Q. Sure. When patients come to you they I presume**
5 **describe their symptoms.**
6 **Right?**
7 A. Yes.
8 **Q. And when they do that they tell you I think I**
9 **have X, Y, Z ---**
10 ATTORNEY BLOCK: Objection to form.
11 BY ATTORNEY TRYON:
12 **Q. --- illness or problem?**
13 ATTORNEY BLOCK: Objection to form.
14 THE WITNESS: Can you rephrase that
15 question? I don't understand.
16 BY ATTORNEY TRYON:
17 **Q. Sometimes when I go to my doctor I say I'm**
18 **experiencing these symptoms and I think this is what it**
19 **is. I think I've got a cold or I think I have got --- I**
20 **don't know Parkinson's disease or something. And then**
21 **the doctor will either say yes, no, maybe, need to run**
22 **more tests. Tell me about when patients come to you.**
23 **Do they just give you their symptoms and say what's**
24 **wrong with me or do they sometimes say I think this is**

Page 48

1 **what's wrong with me, am I right or am I wrong?**
2 A. It would be the former. They would tell me what
3 they are experiencing and then I ask additional
4 questions and make further assessments and
5 recommendations based on what I see in the history and
6 the physical exam.
7 **Q. So for example, if they come to you and say I**
8 **think I have --- nobody comes to you and says I think I**
9 **have the flu?**
10 ATTORNEY JONES: Objection to form.
11 THE WITNESS: Can you rephrase that
12 question?
13 BY ATTORNEY TRYON:
14 **Q. Has anyone come to you and say --- and said I**
15 **think I have chronic depression?**
16 A. Yes.
17 **Q. Do you take that at face value or do you ask**
18 **further questions?**
19 A. I ask further questions.
20 **Q. So that's what I'm referring to as a self**
21 **diagnosis. Someone comes to you and says I think I have**
22 **chronic depression. Can you tell me how often people**
23 **come in to you, youth come in to you with a self**
24 **diagnosis?**

Page 49

1 ATTORNEY BLOCK: Objection to form.
2 ATTORNEY JONES: Objection to form.
3 THE WITNESS: I don't know what
4 percentages that would be.
5 BY ATTORNEY TRYON:
6 **Q. You indicated you are involved in diagnosing and**
7 **treating what is typically known as gender dysphoria.**
8 **Is that right?**
9 A. Yes.
10 **Q. What percentage of your practice involves that**
11 **type of medical issue?**
12 A. By my estimation, around 70 to 80 percent.
13 **Q. And how often do these types of patients come to**
14 **you with a self diagnosis saying I think I have gender**
15 **dysphoria?**
16 A. I don't know that number.
17 **Q. Does it happen?**
18 A. Yes.
19 **Q. Would you estimate it's more than ten percent?**
20 A. I don't know.
21 **Q. But you recall that some have done that.**
22 **Right?**
23 A. Yes.
24 **Q. And of those that do self diagnose with gender**

1 **dysphoria, have you ever come up with a different**
2 **diagnosis for them?**
3 A. Yes.
4 **Q. What are some alternative diagnoses that you**
5 **have given?**
6 A. Eating disorders.
7 **Q. Anything else?**
8 A. That's as I recall.
9 **Q. How many times has that happened?**
10 A. I don't know the percentages.
11 **Q. As far as is it 1, 2, 20, not in percentage but**
12 **absolute numbers?**
13 A. That I do not know.
14 **Q. Could it be just one?**
15 A. That I don't know.
16 **Q. So when you mention eating disorders, were you**
17 **thinking of a particular case?**
18 ATTORNEY JONES: Objection to scope.
19 THE WITNESS: I don't understand the
20 question.
21 BY ATTORNEY TRYON:
22 **Q. Well, I asked you of those that self diagnose**
23 **with gender dysphoria issues, have you ever come up with**
24 **a different diagnosis. You said yes. And I asked you**

1 **what and you said eating disorders. So I'm asking you**
2 **was that a specific patient you recall?**
3 A. No.
4 **Q. Do you remember any specific patients where**
5 **you've given them a different diagnosis?**
6 A. Yes.
7 **Q. How many?**
8 A. That number I don't know off the top of my head.
9 **Q. Well, you're thinking of one person at least.**
10 **Was it more than one?**
11 ATTORNEY JONES: Objection. Asked and
12 answered.
13 BY ATTORNEY TRYON:
14 **Q. Go ahead.**
15 A. Can you repeat the question?
16 **Q. I said you were thinking of one person at least.**
17 **Do you recall more than one?**
18 A. Yes.
19 ATTORNEY JONES: Same objection.
20 BY ATTORNEY TRYON:
21 **Q. Do you recall more than five?**
22 A. No.
23 **Q. Let me ask about the --- let me start that over.**
24 **Let me ask you about the intake process for new**

1 **patients. How does that happen? Does a new patient**
2 **call in or is a new patient referred to you?**
3 A. It's a combination of both.
4 **Q. When that happens and they --- who gathers**
5 **information on this person --- on this patient first?**
6 **Would that be you or a secretary or a nurse?**
7 A. Initially it would be the schedulers to get
8 their basic information. That would be the first point
9 of contact.
10 **Q. And does the scheduler then set up something in**
11 **a system with the patient's name and information?**
12 A. Yes.
13 **Q. What is that system?**
14 A. Can you clarify the question?
15 **Q. Sure. Is there a particular software that is**
16 **used?**
17 A. Yes.
18 **Q. What is that?**
19 A. Epic, currently.
20 **Q. How long has it been Epic?**
21 A. For our clinic, since 2020. February of 2020.
22 **Q. Before 2020 what was it?**
23 A. Cerner.
24 **Q. Sorry?**

1 A. Cerner, C-E-R-N-E-R.
2 **Q. Now, you said you see patients outside the**
3 **clinic.**
4 **Right?**
5 A. Yes.
6 **Q. Sorry. Where is that again?**
7 A. The University of Pittsburgh Student Health
8 Center.
9 **Q. Does that use the same system?**
10 A. No.
11 **Q. What system does that use?**
12 ATTORNEY JONES: Objection, scope.
13 ATTORNEY TRYON: Let me back up.
14 BY ATTORNEY TRYON:
15 **Q. Let me ask you this question because ultimately**
16 **I just want to focus on BPJ. So BPJ came to see you at**
17 **the clinic or at the University of Pittsburgh?**
18 A. At the clinic.
19 **Q. So at the clinic, if I understand correctly, the**
20 **scheduler will set up the initial record.**
21 **Is that right?**
22 A. Yes.
23 **Q. And then when the patient comes in will there be**
24 **additional information sought from the patient?**

Page 54

1 A. The social worker usually calls the patient
2 beforehand to get a sense of what that patient's needs
3 are.
4 **Q. And then what happens?**
5 A. And then the social work team provides me with
6 that information on the electronic medical records that
7 would help me put things into context.
8 **Q. So the social worker calls the patient and**
9 **inputs --- talks to the patient and inputs information**
10 **into the system.**
11 **Is that right?**
12 A. Yes.
13 **Q. At some point the patient comes into the clinic.**
14 **Right?**
15 A. Yes.
16 **Q. I suppose especially during COVID that sometimes**
17 **these things are handled remotely. Did that happen**
18 **during the COVID period?**
19 A. Yes.
20 **Q. Now, does a nurse meet with the patient before**
21 **you do or are you the first contact?**
22 A. The medical assistant --- let me back up. I
23 apologize. It's the schedulers that first meet the
24 patients when they register and they check in the

Page 55

1 clinic.
2 **Q. And then what happens?**
3 A. Then the medical assistant comes out and take
4 the patient's vitals and a short history of their
5 complaints and their medications.
6 **Q. When you say medical assistant, can you tell me**
7 **what that means?**
8 A. That would be a professional who helps take
9 vitals and rooms the patient.
10 **Q. Is that --- would a nurse be a medical**
11 **assistant?**
12 A. Sometimes.
13 **Q. Other than nurses, who would be medical**
14 **assistants?**
15 A. Anyone with a certification in medical
16 assistance.
17 **Q. So is the term medical assistant an actual**
18 **title?**
19 A. Yes.
20 **Q. If there are other --- if there are prior**
21 **medical providers, would the medical assistant or the**
22 **scheduler get those records or get any records from**
23 **prior medical providers before you see the patient?**
24 A. Yes.

Page 56

1 **Q. How would that process happen?**
2 A. Typically, the patient would request to forward
3 the medical records to our office.
4 **Q. Now, I just want to make sure I understand one**
5 **thing about the systems that are being used. Before**
6 **February 2020, the Cerner system was used. And then**
7 **when you --- when the clinic started using Epic, were**
8 **all of the records transferred from Cerner into Epic?**
9 A. Not all.
10 **Q. Which ones were not?**
11 A. Typically, it would be phone conversations.
12 Those are not usually transferred over.
13 **Q. So the clinic's use of Epic, is that tied into**
14 **other medical providers besides just the clinic?**
15 A. I don't understand the question.
16 **Q. Sure. Epic has an ability to, as I understand**
17 **it, to tie systems together from various hospitals or**
18 **other medical providers, whether it's individual doctors**
19 **or clinics. Are you aware of that capability of Epic?**
20 A. Yes.
21 **Q. And so my question is with respect to the**
22 **clinics' use of Epic, is it tied into any other medical**
23 **providers or hospitals or systems besides just the**
24 **clinics?**

Page 57

1 A. They have something called Care Everywhere and
2 so that allows them to gain or obtain records from other
3 facilities.
4 **Q. And do you know what the clinic is tied into,**
5 **what other facilities through Care Everywhere?**
6 A. Can you rephrase that question? I don't
7 understand.
8 **Q. Sure. So in the Epic system at the clinic, can**
9 **you access records from say the West Virginia ---**
10 **University of West Virginia Medicine?**
11 A. Sometimes.
12 **Q. Why only sometimes?**
13 A. Not everyone shares their records. So it is not
14 always consistent.
15 ATTORNEY JONES: Objection. I think
16 we're getting off track, off scope. So objection to the
17 scope.
18 BY ATTORNEY TRYON:
19 **Q. What information do you need to make a diagnosis**
20 **of a problem?**
21 ATTORNEY JONES: Objection.
22 BY ATTORNEY TRYON:
23 **Q. Let me be more specific. What are objective**
24 **symptoms?**

Page 58

1 ATTORNEY JONES: Objection to form.
2 ATTORNEY BLOCK: Objection to form.
3 THE WITNESS: Can you rephrase the
4 question?
5 BY ATTORNEY TRYON:
6 **Q. When I say an objective symptom, do you know**
7 **what that means?**
8 A. It doesn't make sense, the term objective
9 symptom.
10 **Q. Do you know what a subjective symptom is?**
11 A. Yes.
12 **Q. What's a subjective symptom?**
13 A. Basically a symptom that the patient reports.
14 **Q. Is there any way to measure subjective symptoms?**
15 A. It depends.
16 **Q. On what?**
17 A. The type of symptom.
18 **Q. Can you tell me of a symptom that you can**
19 **measure, a subjective symptom that you can measure?**
20 A. Depression.
21 **Q. How do you measure depression?**
22 A. We --- in our practice we do what we call a
23 Patient Health Questionnaire. It's a series of
24 questions that describes or measures the severity of

Page 59

1 depression.
2 **Q. But isn't that still asking the patient**
3 **subjectively the patient's subjective feelings?**
4 A. Yes.
5 **Q. Would an objective symptom be something you**
6 **could observe externally such as a broken arm through an**
7 **x-ray?**
8 ATTORNEY BLOCK: Objection to form.
9 THE WITNESS: Yes.
10 BY ATTORNEY TRYON:
11 **Q. What's --- is the intake process for someone**
12 **coming to you with gender dysphoria issues different**
13 **than a person coming to you for other types of medical**
14 **issues?**
15 ATTORNEY JONES: Objection to
16 terminology.
17 ATTORNEY BLOCK: Same.
18 THE WITNESS: Can you rephrase the
19 question?
20 BY ATTORNEY TRYON:
21 **Q. So you've indicated that you treat patients for**
22 **a lot of different things, and I'm just interested if**
23 **there is a different intake process for someone with**
24 **gender dysphoria as opposed to any other types of**

Page 60

1 **issues?**
2 ATTORNEY JONES: Same objections.
3 THE WITNESS: Is there a different way
4 you can ask that question?
5 BY ATTORNEY TRYON:
6 **Q. When someone calls to you, speak to the**
7 **scheduler and they have gender dysphoria issues, what do**
8 **they typically tell the scheduler?**
9 ATTORNEY BLOCK: Objection to form.
10 ATTORNEY JONES: Same.
11 THE WITNESS: Is there another way you
12 could phrase that question?
13 BY ATTORNEY TRYON:
14 **Q. Tell me about the term gender dysphoria. What**
15 **does that mean to you?**
16 A. That is a distressing feeling an individual has
17 when their gender identity does not match their physical
18 body.
19 **Q. How do you typically get patients that have**
20 **issues with gender identity?**
21 A. There are two ways. You may have another
22 provider refer that patient to me or they come to my
23 clinic on their own volition.
24 **Q. When they come to your clinic on their own**

Page 61

1 **volition, do you know what they say to the scheduler?**
2 A. In our typical practice, they would basically
3 say they have gender issues.
4 **Q. Does the scheduler handle people who say they**
5 **have gender issues any differently than any other types**
6 **of medical issues?**
7 ATTORNEY JONES: Objection to form. If
8 you understand, you can answer.
9 THE WITNESS: No, they don't treat them
10 any differently.
11 BY ATTORNEY TRYON:
12 **Q. Are you familiar with the term gender**
13 **nonconformity?**
14 A. Yes.
15 **Q. And how do you describe gender nonconformity?**
16 A. That is when someone's mannerisms and behaviors
17 do not conform to what a society's view of gender.
18 **Q. Do you have patients come to you who only have**
19 **gender nonconformity but not gender dysphoria?**
20 A. Yes.
21 **Q. How do you distinguish between those?**
22 A. You talk to the patient.
23 **Q. You talk to the patient and how do you make a**
24 **determination which it is?**

1 A. Typically, for example, if a patient wears
2 skirts and they say, well, I still identify as the sex
3 assigned at birth, so in this case male, then that would
4 be more gender nonconforming.
5 **Q. So the distinction is if they say they identify**
6 **as male or female, that's the distinction?**
7 ATTORNEY BLOCK: Objection to form.
8 ATTORNEY JONES: Objection.
9 THE WITNESS: Is there another way you
10 can ask that question?
11 BY ATTORNEY TRYON:
12 **Q. So a male --- in your hypothetical, a male comes**
13 **in and says I have got a --- I am wearing a skirt, but I**
14 **still identify as a male. Then that person would have**
15 **gender nonconformity.**
16 **Is that right?**
17 A. Yes.
18 **Q. But if that same person said I identify as a**
19 **female, then that person would have gender dysphoria.**
20 **Is that right?**
21 ATTORNEY BLOCK: Objection to form.
22 THE WITNESS: Can you rephrase that
23 question?
24 BY ATTORNEY TRYON:

1 **Q. In what you just told me, if a patient comes in**
2 **who is a male wearing a skirt and says I identify as a**
3 **male, that person you said would have gender**
4 **nonconformity. But if that person instead says I**
5 **identify as a female, then would that mean that person**
6 **has gender dysphoria?**
7 ATTORNEY JONES: Objection to form.
8 THE WITNESS: Not always, because that's
9 not how we determine that.
10 BY ATTORNEY TRYON:
11 **Q. Okay.**
12 **So how do you determine that?**
13 A. Which one? Can you be specific?
14 **Q. The child or person comes in, is a male wearing**
15 **a skirt, says I identify as a female. How would you**
16 **determine if that person has gender dysphoria or gender**
17 **nonconformity?**
18 A. We do an assessment when we ask the patient some
19 questions about their behaviors. And they would have
20 their parents, too, so we would also interview the
21 parents, to get a sense of this person's behavior. And
22 then, based on what the patient tells us and our
23 objective findings, then we make the determination if
24 this person may be suffering from gender dysphoria or

1 this person is just gender nonconforming.
2 **Q. Do you have a list of questions?**
3 A. Yes.
4 **Q. Is that list of questions on the Epic system?**
5 A. Yes.
6 **Q. Is it a form that you give to the patient?**
7 ATTORNEY JONES: Objection to form.
8 THE WITNESS: I understand the question.
9 No, we don't give that form to the patient.
10 BY ATTORNEY TRYON:
11 **Q. Are there any qualifications for a medical**
12 **professional to give a diagnosis of gender dysphoria?**
13 A. Can you be --- can you rephrase that question?
14 I don't understand.
15 **Q. Sure. Can just any doctor give a diagnosis of**
16 **gender dysphoria or do they have to have some other**
17 **qualifications?**
18 A. What do you mean by qualifications?
19 **Q. Professional qualifications.**
20 A. To answer that question, there isn't a
21 certification or degree or anything of that sort for
22 qualifications. But in terms of training and the
23 ability to do so, there are some recommendations that
24 they should have to make that diagnosis.

1 **Q. Who gives those recommendation?**
2 A. WPATH and the Endocrine Society.
3 **Q. What is the purpose of getting a diagnosis of**
4 **gender dysphoria?**
5 ATTORNEY JONES: Objection to form.
6 THE WITNESS: Is there a different way
7 you could ask that question?
8 BY ATTORNEY TRYON:
9 **Q. Sure. Is it necessary for some purpose that a**
10 **person receive a diagnosis of gender dysphoria?**
11 ATTORNEY BLOCK: Objection to form.
12 THE WITNESS: Is there a different way
13 you can ask that question?
14 BY ATTORNEY TRYON:
15 **Q. Let me give you an example. Before I had my**
16 **appendix taken out, the doctor needs to do a diagnosis**
17 **that says that I need to get my appendix taken out. So**
18 **that diagnosis of a problem with my appendix, whatever**
19 **it is, is necessary for the operation. Is there any**
20 **need for a diagnosis of gender dysphoria or is it just**
21 **something that people come to understand what's wrong**
22 **with them, not wrong, but what's different about them?**
23 ATTORNEY BLOCK: Objection to form.
24 ATTORNEY TRYON: That's not even the

1 right way to say it.
2 BY ATTORNEY TRYON:
3 **Q. That there's something about them that they are**
4 **trying to understand, is that the only purpose of a**
5 **diagnosis of gender dysphoria?**
6 ATTORNEY JONES: Objection to form.
7 THE WITNESS: I understand the question.
8 It is actually both. Some people are looking to
9 understand what's going on and at the same time in order
10 to receive any treatment in the healthcare system they
11 need a diagnosis.
12 BY ATTORNEY TRYON:
13 **Q. How many of your patients --- let me try and**
14 **establish the right terminology from your perspective.**
15 **As far as gender dysphoria, is it considered a medical**
16 **condition?**
17 A. No.
18 **Q. What is it considered?**
19 A. It's a mental health condition.
20 **Q. I'm sorry. You said it's a mental health**
21 **condition?**
22 A. Yes.
23 **Q. The patients that you see with gender dysphoria,**
24 **how often is it that they've already been diagnosed with**

1 **gender dysphoria versus a first-time approach to you**
2 **asking you about the --- this condition?**
3 A. I don't know the exact numbers off the top of my
4 head.
5 **Q. Can you give me an approximation?**
6 A. That, I don't know.
7 **Q. Are you familiar with the concept of watchful**
8 **waiting?**
9 A. Yes.
10 **Q. Have you ever told any of your patients about**
11 **watchful waiting?**
12 A. No.
13 **Q. So you never recommended that to anyone? Is**
14 **that a true statement?**
15 A. Yes.
16 **Q. What do you know about the concept of watchful**
17 **waiting?**
18 A. It's a concept in which you do not do any
19 interventions for the child to see how the gender
20 dysphoria may worsen or improve without it.
21 **Q. What's your under --- basis of your**
22 **understanding of the concept of watchful waiting?**
23 A. I don't understand the question.
24 **Q. Where have you learned your information about**

1 **watchful waiting?**
2 A. I learned it in --- when I read about the
3 guidelines or when I talk to my colleagues or in
4 professional conferences because this is something that
5 is discussed amongst us.
6 **Q. Any particular papers you've read on it?**
7 A. That, I don't recall which particular papers.
8 **Q. Did you read the original Dutch study?**
9 ATTORNEY BLOCK: Objection to scope.
10 ATTORNEY JONES: Objection to scope.
11 BY ATTORNEY TRYON:
12 **Q. Did you read the original Dutch study?**
13 ATTORNEY BLOCK: Objection to form.
14 ATTORNEY JONES: Objection to form. Go
15 ahead.
16 THE WITNESS: I'm aware of the Dutch
17 study.
18 BY ATTORNEY TRYON:
19 **Q. Did you read it?**
20 ATTORNEY JONES: Same objections.
21 THE WITNESS: Is there any way you could
22 ask that question differently?
23 BY ATTORNEY TRYON:
24 **Q. You said you were aware of the Dutch study. I'm**

1 **asking if you read it?**
2 A. That I don't recall the exact details.
3 **Q. So you don't recall reading it?**
4 A. Correct.
5 **Q. When you give the diagnosis of gender dysphoria,**
6 **you said sometimes that's necessary for treatment. What**
7 **treatment would that be necessary for?**
8 A. Can you rephrase the question?
9 **Q. Are there treatments which require a diagnosis**
10 **of gender dysphoria?**
11 A. Yes.
12 **Q. What are those treatments?**
13 A. That would include puberty blockers,
14 gender-affirming hormones and surgeries and even mental
15 health treatments.
16 **Q. Are you familiar with the WPATH standards of**
17 **care?**
18 A. Yes.
19 ATTORNEY TRYON: Jacob, can you bring up
20 --- actually, no, I think I can do this.
21 ATTORNEY BLOCK: David, it has been about
22 an hour and a half. I just wanted to see if anyone
23 needs a break.
24 ATTORNEY TRYON: Yeah, if we want to take

1 a break we can take a break now. Or keep on going,
2 whatever you prefer.
3 THE WITNESS: I could take a break.
4 ATTORNEY TRYON: And I'll be going past
5 lunchtime. I'm probably halfway through. So we can
6 consider whether or not we want to take lunch or keep
7 going all the way through. But we can talk about that
8 later. Why don't we take a five-minute break right now?
9 THE WITNESS: Thank you.
10 VIDEOGRAPHER: Going off the record.
11 Current time reads 11:37 a.m.
12 OFF VIDEOTAPE
13 ---
14 (WHEREUPON, A SHORT BREAK WAS TAKEN.)
15 ---
16 ON VIDEOTAPE
17 VIDEOGRAPHER: Back on the record.
18 Current time reads 11:45 a.m.
19 ATTORNEY TRYON: Okay.
20 I'm going to try and share Exhibit 33
21 here. Jacob, do I just click on sharing or open?
22 VIDEOGRAPHER: Right.
23 ATTORNEY JONES:
24 Is this the --- for clarification, is

1 this the documents that you just sent to me?
2 ATTORNEY TRYON: These are documents ---
3 this is document from before. It's the standards of
4 care for WPATH.
5 ATTORNEY JONES: Okay.
6 VIDEOGRAPHER: You will hit open and then
7 that opens it for you. And then you'll hit start and
8 that shares it with everyone.
9 ATTORNEY TRYON: Okay.
10 So I hit start. Do people see standards
11 of care?
12 THE WITNESS: Yes.
13 BY ATTORNEY TRYON:
14 **Q. Great. You're familiar with WPATH's Standards**
15 **of Care.**
16 **Right?**
17 A. Yes.
18 **Q. And the most recent version is the 7th version.**
19 **Is that right?**
20 A. Yes.
21 **Q. So you can see at the top up here --- and you**
22 **can zoom in on your own, I believe, if it's too small.**
23 **It says 7th version Standards --- under Standards of**
24 **Care.**

1 **Do you see that?**
2 A. Yes.
3 **Q. So I would like to go to page 11. No, that's**
4 **not the right page. Sorry.**
5 ATTORNEY JONES: I'm just going to object
6 to the scope. Just making a standing objection.
7 ATTORNEY TRYON: Okay.
8 This is the page I want to ---.
9 BY ATTORNEY TRYON:
10 **Q. So take a look at page 11 there. And this is**
11 **directly relevant to this situation, and ask you a**
12 **question about the first two paragraphs.**
13 A. I have read it.
14 **Q. Let me know when you are ready to discuss those.**
15 A. I'm ready.
16 **Q. Okay.**
17 **So in the first paragraph under the title**
18 **differences between children and adolescents with gender**
19 **dysphoria it says that gender dysphoria during childhood**
20 **does not inevitably continue into adulthood rather in**
21 **follow-up studies of prepubertal children, mainly boys,**
22 **who were referred to clinics for assessment of gender**
23 **dysphoria, the dysphoria persisted into adulthood were**
24 **only 6 to 23 percent of children. Boys in these studies**

1 **more likely to identify as gay in adulthood than as**
2 **transgender. My question is do you ever disclose this**
3 **information to your patients?**
4 ATTORNEY JONES: Objection to form.
5 THE WITNESS: Is there a different way
6 you could ask that question?
7 BY ATTORNEY TRYON:
8 **Q. Pardon me?**
9 A. Is there a different way you can ask that
10 question, meaning --- what I mean is that specific
11 information or the fact that not every one ends up being
12 trans?
13 **Q. Do you disclose to any of your patients that**
14 **prepubertal children with gender dysphoria that**
15 **statistically it only persists into adulthood for only 6**
16 **to 23 percent of children?**
17 ATTORNEY BLOCK: Objection to form.
18 ATTORNEY JONES: Objection to form.
19 THE WITNESS: To answer your question, I
20 don't cite those statistics. I just say that it is a
21 possibility.
22 BY ATTORNEY TRYON:
23 **Q. So you tell your patients that is a possibility**
24 **that gender dysphoria may not persist into adulthood.**

Page 74

1 **Is that a fair statement?**
2 A. Yes.
3 **Q. Do you tell all of your patients that?**
4 A. Yes.
5 **Q. Do you give them any percentages at all?**
6 A. No.
7 **Q. Do you just say it is a possibility?**
8 A. Yes.
9 ATTORNEY JONES: Objection to form.
10 BY ATTORNEY TRYON:
11 **Q. Do any of your --- okay.**
12 **Are there standards that you use --- we're done**
13 **with that exhibit for now. Are there standards that you**
14 **use for diagnosing gender dysphoria?**
15 A. By standards, do you mean guidelines?
16 **Q. Yes.**
17 A. Yes.
18 **Q. What's the source of those guidelines?**
19 A. And by guidelines do you mean like position
20 papers or which organizations?
21 **Q. Yes.**
22 A. I use several, including WPATH, the Endocrine
23 Society and the University of California, San Francisco
24 Guidelines.

Page 75

1 **Q. Do you use DSM-V?**
2 A. Yes.
3 **Q. Now, I have not heard of the University of**
4 **California, San Francisco Guidelines. What are those?**
5 A. They are a set of guidelines on how to work and
6 manage people with gender dysphoria.
7 **Q. Are those different from DSM-V as far as**
8 **diagnosing gender dysphoria?**
9 A. No DSM-V focuses on criteria for diagnosis where
10 UCSF focuses more on medical management.
11 **Q. Is there anything different between DSM-V and**
12 **WPATH?**
13 A. None to my knowledge.
14 **Q. Is there any difference between the DSM-V**
15 **Guidelines and the Endocrine Society Guidelines?**
16 A. None to my knowledge.
17 **Q. Who came up with standards for DSM-V?**
18 A. From an organizational perspective, it would be
19 American ---.
20 **Q. I'm afraid I didn't hear you.**
21 A. It would be the American Psychological
22 Association who writes the DSM-V.
23 **Q. And is there a particular group within the**
24 **American Psychological Association that writes the**

Page 76

1 **standards?**
2 ATTORNEY JONES: Objection to scope.
3 THE WITNESS: There is. I just don't
4 know the exact name of that group.
5 BY ATTORNEY TRYON:
6 **Q. Fair enough. Do you know if there is an**
7 **approval process for those standards?**
8 ATTORNEY BLOCK: Objection to scope.
9 ATTORNEY JONES: Objection to scope.
10 THE WITNESS: From my knowledge, yes,
11 there's an approval process.
12 BY ATTORNEY TRYON:
13 **Q. Are there disputes about those standards?**
14 ATTORNEY JONES: Objection to scope.
15 ATTORNEY BLOCK: Objection to scope.
16 ATTORNEY JONES: And objection to form.
17 BY ATTORNEY TRYON:
18 **Q. Are you aware of any disputes as to those**
19 **standards?**
20 ATTORNEY JONES: Objection to scope and
21 objection to form.
22 THE WITNESS: By dispute, do you mean
23 some mild disagreement in how this is done or like a
24 rift?

Page 77

1 BY ATTORNEY TRYON:
2 **Q. Well, let's start with a rift. Are you aware of**
3 **any rifts in the medical community which dispute the**
4 **methodology of DSM-V for diagnosing gender dysphoria?**
5 ATTORNEY BLOCK: Objection to the scope.
6 This is a lay witness.
7 ATTORNEY JONES: He's not an expert in
8 this. He's made that perfectly clear. I'm going to
9 instruct him not to answer. We're getting into expert
10 testimony.
11 ATTORNEY TRYON: Well, no it's not expert
12 testimony, but maybe I'll lay a foundation a little bit
13 differently for you.
14 BY ATTORNEY TRYON:
15 **Q. So you use DSM-V. Are there other standards out**
16 **there that you could use that disagree with DSM-V?**
17 ATTORNEY JONES: Objection to form.
18 THE WITNESS: There isn't any other set
19 of criteria that would oppose DSM-V, if that's the word
20 you use.
21 BY ATTORNEY TRYON:
22 **Q. It is different for adults and adolescents and**
23 **children in DSM-V.**
24 **Right?**

1 ATTORNEY BLOCK: Objection to form.
2 ATTORNEY JONES: Objection to form.
3 THE WITNESS: Can you rephrase the
4 question?
5 BY ATTORNEY TRYON:
6 **Q. The standards for diagnosing gender dysphoria is**
7 **different for adults and adolescents and children under**
8 **DSM-V.**
9 **Right?**
10 A. Yes.
11 **Q. Are you ---?**
12 ATTORNEY JONES: Again, I think that
13 we're getting off track here. And I hate to make this
14 speaking objection, but you're asking him differences in
15 standards of care and he's here to talk about the care
16 and the treatment of BPJ. I think you can ask him about
17 his care and treatment of BPJ, but I think you're
18 getting off track with the scope.
19 ATTORNEY TRYON: Yeah. And just to be
20 clear, we're establishing what sort of the baseline,
21 which I think is totally appropriate here. I'm going to
22 keep on moving on.
23 ATTORNEY JONES: Well, I think --- I
24 think you can ask him what he used for his baseline.

1 ATTORNEY TRYON: I think I have just done
2 that, but keep on moving.
3 ATTORNEY JONES: I'll keep on objecting.
4 ATTORNEY TRYON: Okay.
5 BY ATTORNEY TRYON:
6 **Q. So let's talk about BPJ. Do you have any**
7 **personal relationship with BPJ or BPJ's family?**
8 A. Personal relationship? No.
9 **Q. And how did the professional relationship with**
10 **BPJ or BPJ's family start?**
11 A. They made an appointment to see me at the
12 clinic.
13 **Q. Do you remember when that was?**
14 A. July 15th, 2019.
15 **Q. Was that when they made the appointment or when**
16 **the appointment actually was?**
17 A. That's the actual date of the appointment.
18 **Q. Do you know how that appointment was made,**
19 **whether it was through a referral or just a direct phone**
20 **call or something else?**
21 A. It was a self referral --- I correct myself.
22 **Q. I'm sorry. There's some interference. I**
23 **couldn't hear you.**
24 A. I recall that a pediatrician referred them.

1 **Q. What pediatrician referred them?**
2 A. I don't recall the name of the pediatrician.
3 **Q. Do you remember that first visit?**
4 A. Yes.
5 **Q. Tell me about that.**
6 A. Can you be more specific?
7 **Q. Do you remember when you first saw them, their**
8 **appearances?**
9 A. Yes.
10 **Q. Who was there?**
11 A. B[redacted] --- BPJ and her mother.
12 **Q. Did someone see them on that --- let me back up.**
13 **You saw them at the clinic.**
14 **Is that right?**
15 A. Yes.
16 **Q. Did someone at the clinic see them before you**
17 **did?**
18 A. No.
19 **Q. Not even the scheduler?**
20 A. I correct myself. So if you meant like another
21 professional than me, no. But yes, they did --- the MA
22 as part of the check-in process.
23 **Q. As part of the check-in process would another**
24 **medical professional have then taken BPJ's vitals and**

1 **other information?**
2 A. Yes.
3 **Q. Before you met BPJ and the mother --- the mother**
4 **is Heather Jackson.**
5 **Is that right?**
6 A. Yes.
7 **Q. And before you met with them did you have any**
8 **written materials to look at before you actually met**
9 **with them in person?**
10 A. By written materials do you mean like previous
11 medical records.
12 **Q. Either previous medical records or any**
13 **information that had been typed into the system by**
14 **anyone else?**
15 A. I have reviewed those ---.
16 **Q. I'm sorry. You're breaking up. I can't hear**
17 **you.**
18 **---**
19 **(WHEREUPON, AN OFF RECORD DISCUSSION WAS HELD.)**
20 **---**
21 BY ATTORNEY TRYON:
22 **Q. Let's go back.**
23 A. Can you remind me what was the last question?
24 **Q. I'm thinking here. Before you --- let me ask a**

Page 82

1 **different question. So you actually met with them in**
2 **person as opposed to a televisit.**
3 **Right?**
4 A. Yes.
5 **Q. And before you actually met with them, did you**
6 **review anything --- any --- either medical records or**
7 **anything that any of your assistants or staff had typed**
8 **into the system?**
9 A. Yes.
10 **Q. What did you review?**
11 A. One of the things I reviewed was the social work
12 note that, as I had told earlier, usually calls the
13 patient before we see them.
14 **Q. Do you remember what was in those social worker**
15 **notes?**
16 A. Basically for that note they said they tried
17 contacting that patient and they didn't pick up.
18 **Q. Anything else that you reviewed that was in**
19 **writing?**
20 A. Just the patient's vitals and the reason why
21 they're here.
22 **Q. So tell me about that visit. When you first met**
23 **with them, did Heather Jackson speak first or did BPJ**
24 **speak first?**

Page 83

1 A. I believe that BPJ spoke first.
2 **Q. What did BPJ tell you?**
3 A. As I recall, she was --- she told me that she
4 was concerned about going into puberty.
5 **Q. Anything else that you can recall as you sit**
6 **here?**
7 A. That's the initial thing I recall.
8 **Q. How about Heather Jackson, do you remember**
9 **anything that she said?**
10 A. Not without looking at my notes.
11 **Q. Fair enough. Do you remember anything that you**
12 **told them?**
13 A. Yes.
14 **Q. What did you tell them?**
15 A. I counseled them about all --- you know, what
16 would the visit look like and what kind of options are
17 available and how we could help them. That's part of my
18 custom and practice.
19 **Q. At that time did you ask questions in order to**
20 **determine if BPJ should be diagnosed with gender**
21 **dysphoria?**
22 A. Yes.
23 **Q. Did BPJ tell you that BPJ had gender dysphoria?**
24 A. No.

Page 84

1 **Q. Did Heather tell you that?**
2 A. No.
3 **Q. At that time did you do a psychodiagnostic**
4 **assessment of BPJ?**
5 A. I did a psychosocial evaluation.
6 **Q. Is that different than a psychodiagnostic**
7 **assessment?**
8 A. Yes.
9 **Q. How is that different?**
10 A. Because I am asking more questions about the
11 context of that patient and it's not necessarily to make
12 a diagnosis.
13 **Q. Did you do a psychiatric assessment?**
14 A. Can you clarify? What do you mean by
15 psychiatric assessment?
16 **Q. Yes, I can. Let me go back to Exhibit 33. Do**
17 **you see that on your screen?**
18 A. No.
19 VIDEOGRAPHER: Attorney Tryon, did you
20 hit the start button? There you go.
21 BY ATTORNEY TRYON:
22 **Q. Let me know when you see that.**
23 A. I see --- there we go.
24 **Q. Okay.**

Page 85

1 **I want to go to page 15. Okay. This is in the**
2 **WPATH Standards of Care, page 15, item two. It says**
3 **assessment of gender dysphoria and mental health should**
4 **explore the nature and characteristics of a child's or**
5 **adolescent's gender identity. A psychodiagnostic and**
6 **psychiatric assessment covering the areas of emotional**
7 **functioning, peer and other social relationships and**
8 **intellectual functioning, slash, school of achievement**
9 **should be performed. Did you do either --- did you do**
10 **that psychiatric assessment as described here?**
11 A. Yes.
12 **Q. What did that entail?**
13 A. So in adolescent medicine you ask questions
14 about that person's school life and how they are doing
15 in their grades. You screen for any depression. You
16 ask about their eating behaviors. You ask about any
17 substance use and potential for violence in the home,
18 any concerns about their sexual orientation or gender
19 identity and smoking habits and the relationships or at
20 least observe the relationships between their family
21 members.
22 **Q. Is that what you consider a psychiatric**
23 **assessment?**
24 ATTORNEY JONES: Objection to form.

Page 86

1 THE WITNESS: I understand the question.
2 By defined at the WPATH the psychiatric assessment, if
3 they describe the emotional functioning, peer and social
4 relationships and school achievements, then yes, I did
5 something like that.
6 BY ATTORNEY TRYON:
7 **Q. But you indicated I think that a**
8 **psychodiagnostic assessment is different.**
9 **Is that right?**
10 ATTORNEY BLOCK: Objection to form.
11 ATTORNEY JONES: Objection to form.
12 BY ATTORNEY TRYON:
13 **Q. You can answer.**
14 A. From what I understand when you first asked the
15 question, but if reading that and say that a
16 psychodiagnostic and psychiatric assessment includes
17 those things that I ask, then that would be a
18 psychodiagnostic exam.
19 **Q. And how did you document your assessment?**
20 A. There's a form that the patient filled out and I
21 verified.
22 **Q. I'm trying to post Exhibit 36. Let me know when**
23 **you see that.**
24 A. I can see it.

Page 87

1 **Q. Is this the form that you are referring to?**
2 A. Yes.
3 **Q. Did --- do you know who filled this out?**
4 A. BPJ did.
5 **Q. Did BPJ fill this out in your presence?**
6 A. I don't recall.
7 **Q. What is the source of this form?**
8 A. By source do you mean like who created the form
9 or ---?
10 **Q. Created this form?**
11 A. The American Medical Association.
12 **Q. Let me ask you, up in the upper right-hand**
13 **corner here --- just to make sure I understand some of**
14 **the things on this --- it shows DOS 7/15/2019. That**
15 **means the date of service.**
16 **Is that right?**
17 A. Yes.
18 **Q. And this was the first visit you had with BPJ**
19 **and Heather Jackson?**
20 A. Yes.
21 **Q. And then I see in that same area, Epic FIN, and**
22 **then number. What is that?**
23 A. That is the financial information number. It
24 helps with billing.

Page 88

1 **Q. Down lower, under what would you like to talk**
2 **about today and it says other, explain AFAB, do you see**
3 **that?**
4 A. Yes.
5 **Q. What does AFAB mean?**
6 A. The acronym I'm familiar with is assigned female
7 at birth.
8 **Q. Under self it says --- the third question there,**
9 **if you could change one thing about your life or**
10 **yourself would it be --- it says to be a girl, which is**
11 **--- I presume BPJ wrote that.**
12 **Is that right?**
13 A. Yes.
14 **Q. Did you explore why BPJ wanted to be a girl?**
15 A. Can you clarify? What do you mean by exploring?
16 **Q. Did you ask BPJ why BPJ would like to be a girl?**
17 ATTORNEY JONES: Objection to form and
18 terminology.
19 THE WITNESS: In my practice I don't ask
20 the reasons someone wants to be a girl. What I ask is
21 what are the features or what are the behaviors that
22 would be consistent in saying that I am a girl or that
23 patient is a girl.
24 BY ATTORNEY TRYON:

Page 89

1 **Q. And did you ask BPJ that?**
2 A. Yes.
3 **Q. What did BPJ tell you?**
4 A. That she was afraid of going through puberty
5 because she does not want to be a boy, that she dresses
6 as a girl, that she doesn't like her own body, that she
7 prefers people use she/her pronouns and use the name
8 B[redacted], that, as I said, she dresses in a way that is
9 consistent with being a girl, like the clothing, the
10 hairstyle, and that she identifies as a girl.
11 **Q. And why did BPJ --- why was BPJ afraid of being**
12 **a boy?**
13 ATTORNEY JONES: Objection to form.
14 ATTORNEY BLOCK: Object to form.
15 THE WITNESS: I can answer that question.
16 Because she didn't identify as a boy.
17 BY ATTORNEY TRYON:
18 **Q. What was --- what was BPJ afraid of?**
19 ATTORNEY JONES: Objection to form.
20 Asked and answered.
21 THE WITNESS: Can you repeat that
22 question?
23 BY ATTORNEY TRYON:
24 **Q. You said she was afraid of going through puberty**

Page 90

1 **because she does not want to be a boy. Why was she**
2 **afraid of going through puberty?**
3 A. [redacted]
[redacted lines 4–11]
12 BY ATTORNEY TRYON:
13 **Q. Is that a word that you would use or a word that**
14 **BPJ actually used?**
15 A. That is from my own observation.
16 **Q.** [redacted]
[redacted lines 17–21]
22 **Q. Did BPJ --- strike that.**
23 **Did you ask BPJ what it means in BPJ's mind to**
24 **be a girl?**

Page 91

1 ATTORNEY JONES: Form.
2 THE WITNESS: Is there a different way
3 you can ask that question?
4 BY ATTORNEY TRYON:
5 **Q. In the form it says if you could change one**
6 **thing about your life or yourself would it be, BPJ wrote**
7 **to be a girl. Did you ask BPJ what it meant to be a**
8 **girl?**
9 A. If you mean from an existential point, no.
10 **Q. Did you ask anything else --- you may have**
11 **already answered part of this. I apologize if I'm ---**
12 **if I'm asking the same thing. Did you ask BPJ --- let**
13 **me --- and forgive me if I'm asking you to repeat**
14 **yourself. Did you ask BPJ what characteristics of being**
15 **a girl that BPJ wanted?**
16 A. I may have to look at my notes to refresh my
17 memory.
18 **Q. What notes are those?**
19 A. The medical records on the day I saw her.
20 **Q. I see. Okay. We'll get to those in a bit then.**
21 **Do you have any handwritten notes from your visit with**
22 **BPJ and Heather Jackson that day?**
23 A. No.
24 **Q. So the only notes would be what are in the**

Page 92

1 **system.**
2 **Right?**
3 A. Yes.
4 **Q. Let's go to the second page here. Do you see**
5 **under development there's some questions there?**
6 A. Yes.
7 **Q. Did you discuss issues under this category with**
8 **BPJ?**
9 A. Yes.
10 **Q. Tell me about those discussions.**
11 A. So the two main questions I ask that is custom
12 and part of my practice is if you --- what parts of your
13 body do you feel most uncomfortable with. And then if
14 there are anything you would change to make your body
15 fit with who --- with that person's or patient's gender
16 identity.
17 **Q. And what was BPJ's response?**
18 A. [redacted]
[redacted lines 19–20]
21 **Q. The next --- well, I don't know how to**
22 **characterize this, but it says I am romantically or**
23 **sexually attracted to boys,** [redacted]**. Did**
24 **you ask BPJ about that?**

Page 93

1 A. No, I didn't expand upon that.
2 **Q.** [redacted]
[redacted lines 3–5]
6 BY ATTORNEY TRYON:
7 **Q.** [redacted]
[redacted lines 8–13]
14 **Q. Why do you ask that?**
15 A. It provides me a level of that patient's mental
16 health.
17 **Q. Ultimately, did you, in fact, diagnose BPJ with**
18 **gender dysphoria or not?**
19 A. Yes, I diagnosed her with gender dysphoria.
20 **Q. Has anyone else previously or after, to your**
21 **knowledge, diagnosed BPJ with gender dysphoria?**
22 A. Do you mean as in like a second opinion?
23 **Q. I don't know if I would call it second opinion**
24 **or not. I want to know if you know of anyone else**

Page 94

1 **that's actually made a formal diagnosis of gender**
2 **dysphoria for BPJ?**
3 A. That I do not know.
4 **Q. I have been told that there's something called**
5 **--- that gender identity is fluid.**
6 **Is that right?**
7 ATTORNEY BLOCK: Objection to form.
8 ATTORNEY JONES: Form and terminology.
9 ATTORNEY TRYON: Let me back up.
10 BY ATTORNEY TRYON:
11 **Q. What does the term gender identity mean?**
12 A. Gender identity is an immutable characteristic
13 of someone's feeling of either being a woman or a man or
14 something in between or another gender, which could be a
15 combination of bio, psychosocial, societal expectations
16 and their own sense of what their gender identity is.
17 **Q. Can gender identity be fluid?**
18 ATTORNEY JONES: Objection to form.
19 THE WITNESS: It cannot be fluid. It is
20 immutable.
21 BY ATTORNEY TRYON:
22 **Q. So if another medical professional said that**
23 **gender identity is fluid, that person would be wrong in**
24 **your estimation?**

Page 95

1 ATTORNEY JONES: Objection to scope.
2 He's not here as an expert.
3 BY ATTORNEY TRYON:
4 **Q. You can answer.**
5 A. I would say they're using --- that would be
6 incorrect definition of what gender identity is.
7 **Q. I've also been told that gender identity**
8 **evolves. Are you saying --- is that right or wrong?**
9 ATTORNEY BLOCK: Objection to the form.
10 BY ATTORNEY TRYON:
11 **Q. Or that it can evolve. Would that be right or**
12 **wrong.**
13 ATTORNEY BLOCK: Objection to form.
14 ATTORNEY JONES: And scope.
15 THE WITNESS: Can you clarify what do you
16 mean by evolve?
17 BY ATTORNEY TRYON:
18 **Q. Change over time.**
19 A. No.
20 **Q. Have you ever --- is gender identity something**
21 **that is observable externally or only what some person**
22 **feels?**
23 ATTORNEY BLOCK: Objection to form.
24 ATTORNEY JONES: Form. You can answer.

Page 96

1 THE WITNESS: That is something that a
2 person only knows.
3 ATTORNEY TRYON: Jacob, I'm trying to
4 find the documents used previously. Trying to find
5 Exhibit 4.
6 VIDEOGRAPHER: Give me one moment here.
7 That would be --- 4 would be in the one marked 1 through
8 9. Correct?
9 ATTORNEY TRYON: Correct.
10 VIDEOGRAPHER: Okay.
11 It should be shared with you. You might
12 see it in a folder labeled shared with you.
13 ATTORNEY TRYON: Shared with group.
14 There we go. Okay.
15 Jacob, is there a way to get through here
16 without clicking the arrow button so I can get through
17 faster?
18 VIDEOGRAPHER: You can highlight the
19 number and type in, you know, whatever number page you
20 want to go to.
21 ATTORNEY TRYON: Thank you.
22 Okay. This is Exhibit 4.
23 BY ATTORNEY TRYON:
24 **Q. Can you see that, Doctor Montano?**

Page 97

1 A. I cannot see it.
2 **Q. Oh, let me know when you see it.**
3 A. It's loading. Sorry.
4 **Q. That's okay.**
5 A. I see it.
6 **Q. Do you recognize this document?**
7 A. Yes.
8 **Q. What is it?**
9 A. That is the physical documentation when I first
10 saw BPJ.
11 **Q. How is this form filled out? Do you see this**
12 **form just like this on the system and you type in your**
13 **information or is this just a separate internal form**
14 **that then populates this?**
15 A. It's the template within the electronic medical
16 record.
17 **Q. Are you saying this is the actual template or**
18 **there is a template that you --- on the system that you**
19 **type into which then populates this form?**
20 ATTORNEY BLOCK: Objection to form.
21 ATTORNEY JONES: Objection to form.
22 THE WITNESS: Is there --- can you
23 rephrase that question?
24 BY ATTORNEY TRYON:

1 **Q. Yeah. I'm just trying to understand. When you**
2 **--- when --- you don't fill things out in paper, right?**
3 **You do it right on the computer.**
4 **Is that correct?**
5 A. Yes.
6 **Q. And when you pull up --- go to enter information**
7 **on the computer, does the document look like this**
8 **Exhibit 4?**
9 A. Yes, it's like a pre-form template that I use.
10 **Q. And what's the source of the template? Is it**
11 **something that you developed or that UPMC developed or**
12 **something that Epic developed or something else?**
13 A. It's a template I developed.
14 **Q. Is this form in the Epic system now?**
15 A. Yes.
16 **Q. And more than form. I guess I should say ---**
17 **rephrase that. Is this actual document in the Epic**
18 **system?**
19 A. Are you referring to WV 4?
20 **Q. Yes.**
21 A. Yes. It's in the electronical medical record
22 system.
23 **Q. At the top here it has got the designation of**
24 **male.**

1 **Do you see that?**
2 A. Yes.
3 **Q. Why does it say male?**
4 A. Because that is the legal sex of the patient.
5 **Q. Is there any other reason that the designation**
6 **of male should be in here?**
7 ATTORNEY BLOCK: Objection to form.
8 ATTORNEY JONES: Objection to form.
9 THE WITNESS: From my custom and
10 practice, it's important to know what organs that person
11 has. So it's a good thing to know.
12 BY ATTORNEY TRYON:
13 **Q. Does that mean that BPJ is a biological male?**
14 ATTORNEY BLOCK: Objection to form.
15 ATTORNEY JONES: Objection to form.
16 THE WITNESS: The way I would describe it
17 is that B[redacted] or BPJ was assigned male at birth.
18 BY ATTORNEY TRYON:
19 **Q. Does the term biological male have a meaning?**
20 ATTORNEY BLOCK: Objection to form.
21 THE WITNESS: To answer your question, it
22 is a very misleading and to some people offensive
23 meaning.
24 BY ATTORNEY TRYON:

1 **Q. Is it offensive to you?**
2 A. No.
3 **Q. In what way is it misleading?**
4 A. Because it disqualifies someone's gender
5 identity when you describe them as biologically male.
6 **Q. Does the term --- how does the term male as used**
7 **in this document differ from the term biological male?**
8 A. Going back to my assigned male at birth, this is
9 what that patient was assigned at birth typically based
10 on what the doctors see in their genitalia.
11 **Q. Now,** [redacted]
[redacted]
[redacted]
[redacted]
[redacted]
16 **Q. Under desire or secondary sex characteristics of**
17 **other gender, slash, to be other gender, in that part of**
18 **this form can you tell me what part of the template and**
19 **what items you actually inputted?**
20 A. So the heading desire to get rid of secondary
21 sex characteristics and then the expectations for
22 today's visit and then hopes for hormone therapy, those
23 are part of the template. And then the words afterwards
24 are something that I input based on the patient

1 response.
2 **Q. And the words desire for secondary sex**
3 **characteristic of other gender, slash, to be other**
4 **gender, that's part of the template?**
5 A. Yes.
6 **Q. And then severity of wanting to be another**
7 **gender is based on the following, that's part of the**
8 **template?**
9 A. Yes.
10 **Q. And then there's four items underneath that,**
11 **hairstyle, clothing, shoes and name. Are those part of**
12 **the template?**
13 A. Yes.
14 **Q. And the Y after each one of those, is that**
15 **something that you inputted into the system?**
16 A. Yes.
17 **Q. I presume Y stands for yes.**
18 **Correct?**
19 A. Yes. Yes.
20 **Q. So are you the one that created the template**
21 **that listed hairstyle, clothing, shoes and name.**
22 **Is that right?**
23 A. Yes.
24 **Q. Why did you choose those particular four**

Page 102

1 **categories?**
2 A. That was based on my training on what questions
3 would be high yield and also based on my understanding
4 of the criteria for gender dysphoria.
5 **Q. So you just limited it to four there, not ---**
6 **why didn't you have more characteristics?**
7 A. I felt that those would be sufficient enough to
8 indicate someone's desire to be of the other gender.
9 **Q. When it says been expressing herself as female,**
10 **that's template?**
11 A. No, that actually was something I inputted
12 myself.
13 **Q. Okay.**
14 **So including the one year? That question is**
15 **not entirely clear. Let me try again. So it says been**
16 **expressing herself as female, colon, one year. That**
17 **entire phrase is something you inputted separately, not**
18 **part of the template?**
19 A. I'm sorry. I had a recording phrase. I don't
20 know if you said something.
21 **Q. The language, it says been expressing herself as**
22 **female. Is that language part of the template or**
23 **something you typed in?**
24 A. That is something I typed in.

Page 103

1 **Q. And then the one year, you typed that in?**
2 A. Yes.
3 **Q. And that was based on what BPJ and/or BPJ's mom**
4 **told you?**
5 A. Both of them.
6 **Q.** [redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
16 **Q. So I don't really understand what that's saying.**
17 **Can you explain that?**
18 A. To be honest, I don't understand what it means
19 either.
20 **Q. On the next page, under social and psychosocial**
21 **habits it says no data available. Did you type in no**
22 **data available?**
23 A. No.
24 **Q. And the next part says a detailed psychosocial**

Page 104

1 **assessment was conducted and documented confidentially**
2 **and relevant recommendations and health education was**
3 **offered to the patient and family. Is that part of the**
4 **template or is that something you typed in?**
5 A. That is part of the template.
6 **Q. And was that psychosocial assessment conducted?**
7 A. Yes.
8 **Q. And how is it documented?**
9 A. It was documented through that confidential
10 Adolescent Medicine Questionnaire.
11 **Q. The two-page document that we looked at earlier?**
12 A. Yes.
13 **Q. Any other documentation on that psychosocial**
14 **assessment?**
15 A. No.
16 **Q. On the page we're looking at, which is page five**
17 **of 6, also labeled at the bottom BPJ 038, at the top**
18 **there's a part that says we discussed with B[redacted] and her**
19 **parents/caregiver the nature, effects, benefits, et**
20 **cetera.**
21 **Do you see that paragraph?**
22 A. Yes.
23 **Q. How much of that is part of the template and how**
24 **much of that was actually typed in by you?**

Page 105

1 A. That was part of the template, but it's my
2 custom and practice to describe all of that when I'm
3 counseling my patients.
4 **Q. And so it says that you offered a refer to the**
5 **fertility services at Magee Womens Hospital. Why did**
6 **you offer her a referral to the fertility services at**
7 **Magee Womens Hospital?**
8 A. The reason being is that if B[redacted] were to decide
9 to get a puberty blocker, [redacted]
[redacted] [redacted] And so I always --- it's my custom
11 and practice to always counsel my parents that that is a
12 possibility and they should consult with a fertility
13 specialist to understand what would happen if this
14 person were to go or use puberty blockers.
15 **Q. Well, will BPJ be able to produce any eggs with**
16 **or without puberty blockers?**
17 A. I apologize. [redacted]
[redacted] [redacted]
19 **Q. You threw me there. One more question about**
20 **this form, back on the first page, page one of eight I**
21 **think it is. So under history of present illness ---**
22 **OFF VIDEOTAPE**
23 **Q. --- incongruence, it says identifies as**
24 **transgender instead of male. What does it take to**

Page 106

1 **identify as transgender?**
2 A. To stop you right there, I can't see that file.
3 VIDEOGRAPHER: Hold on one second. The
4 witness's video feed cut out for a second and that ended
5 up pausing the recording during your question. The
6 reporter still heard it, though. But let me get
7 everything sorted here real quick.
8 Okay. We are recording again. Doctor
9 Montano, can you see the exhibit right now?
10 THE WITNESS: No.
11 VIDEOGRAPHER: Mr. Tryon, could you do me
12 a favor and just hit stop and then start again?
13 ATTORNEY JONES: Just so you know, I have
14 --- if you would like ---?
15 VIDEOGRAPHER: The witness got cut out
16 again.
17 ATTORNEY TRYON: I can see Mr. Jones. I
18 cannot see the witness.
19 VIDEOGRAPHER: Right. The witness's feed
20 is not here. Mr. Jones, is he losing internet
21 connection on the computer he's using? I'm going to
22 send him a chat.
23 ATTORNEY JONES: I apologize. I would
24 have thought that my --- my office had the capability to

Page 107

1 handle this.
2 ATTORNEY TRYON: Are we all back together
3 again?
4 ATTORNEY JONES: Yes.
5 VIDEOGRAPHER: Give me one second. Mr.
6 Tryon, you might have to do that stop and start again if
7 the witness can't see the exhibit.
8 THE WITNESS: I can see it right now.
9 VIDEOGRAPHER: Oh, okay.
10 ATTORNEY JONES: And I have the document
11 that he's referring to, our copy, in front of him.
12 VIDEOGRAPHER: Okay. We are recording
13 and we are back on the record.
14 ON VIDEOTAPE
15 BY ATTORNEY TRYON:
16 **Q. Independent of this exhibit, did you tell BPJ or**
17 **Heather Jackson that there was a possibility that BPJ**
18 **could --- might not persist with gender dysphoria?**
19 A. It is my custom and practice to discuss that
20 with all of my patients.
21 **Q. Do you remember saying that to BPJ and Heather**
22 **Jackson?**
23 A. Again, it's part of my custom and practice to
24 always bring that up.

Page 108

1 **Q. I understand. Do you remember having that**
2 **discussion with them?**
3 A. Not the specific details, but yes.
4 **Q. Do you remember what their reaction was, the**
5 **response was?**
6 A. I don't remember.
7 **Q. And on the document, Exhibit 4, it says history**
8 **of present illness, incongruence, that much is part of**
9 **the form.**
10 **Right?**
11 A. Yes.
12 **Q. And then the next part says identifies as**
13 **transgender instead of --- instead of male. Is that**
14 **something you typed in?**
15 A. Yes.
16 **Q. And did BPJ say that BPJ identifies as**
17 **transgender or something else and you just**
18 **re-characterized it?**
19 A. I don't recall specifically.
20 **Q. Okay.**
21 **What does it take for someone to identify as**
22 **transgender, to say I identify as transgender, or is**
23 **there something beyond that?**
24 ATTORNEY BLOCK: Objection to form.

Page 109

1 ATTORNEY JONES: Objection to form.
2 THE WITNESS: The criteria for
3 incongruence is someone who states that someone
4 identifies differently from the sex assigned to them at
5 birth.
6 BY ATTORNEY TRYON:
7 **Q. Okay.**
8 **I'm showing you now Exhibit 5. Do you see**
9 **that?**
10 A. Yes.
11 **Q. So this would have been generated through the**
12 **same system --- I mean this appears to have much of the**
13 **same information as the prior document, Exhibit 4, but**
14 **in a different format. At the top it says discharge**
15 **summary. So let me, first of all, ask you if you have**
16 **seen this document before?**
17 A. Yes.
18 **Q. And how is this different from Exhibit 4, which**
19 **is --- is titled Adolescent Medicine, dash, Evaluation?**
20 VIDEOGRAPHER: I have to interrupt you.
21 The witness's video cut out again. It looks like he's
22 back.
23 THE WITNESS: I can still see the form
24 --- oh, I'm frozen.

Page 110

1 BY ATTORNEY TRYON:
2 **Q. Do you see the form or not?**
3 A. I can see the form.
4 **Q. Okay.**
5 **Did you understand my question?**
6 A. Can you repeat the question, please?
7 **Q. Yes. Let me fix my system here. Okay. How is**
8 **this Exhibit 5 differ from Exhibit 4?**
9 A. So the discharge summary is something that we
10 are required by the hospital to give to summarize their
11 care and the next steps for the patient.
12 **Q. Under provider plan there's three items. That's**
13 **information you typed in there.**
14 **Correct?**
15 A. Yes.
16 **Q. And item two, I will contact Doctor Murray in**
17 **Morgantown, West Virginia, to determine if her clinic**
18 **can give pubertal blockers, did you contact Doctor**
19 **Murray?**
20 A. My memory is not clear. I may have to review
21 some of the telephone notes to see if I remember or to
22 help me recall that I did speak with Doctor Murray.
23 **Q. Why were you considering contacting Doctor**
24 **Murray to determine if her clinic could give pubertal**

Page 111

1 **blockers?**
2 A. Because it would be closer to the patient.
3 **Q. Who is Doctor Murray?**
4 A. She is a physician that used to work at West
5 Virginia University Adolescent Medicine.
6 **Q. Where does Doctor Murray work now?**
7 A. Boston Children's.
8 **Q. What is Doctor Murray's first name?**
9 A. Pamela.
10 **Q. Ultimately, Doctor Murray did not give any**
11 **pubertal blockers to BPJ.**
12 **Correct?**
13 A. Yes.
14 **Q. Do you know why?**
15 A. From my recollection, she just didn't do those
16 procedures or give out those medications.
17 **Q. This is Exhibit 6. This is also from the date**
18 **of service of --- I'm sorry. Do you see that?**
19 A. Yes.
20 **Q. Are you looking at a hard copy?**
21 A. I'm looking at both.
22 **Q. Very good. This is also from July 15, 2019 it**
23 **says at the top. Do you see that?**
24 A. Yes.

Page 112

1 **Q. And this is outpatient evaluations. It appears**
2 **to have much the same information again, but it's a**
3 **different form. Can you explain the purpose of this**
4 **form?**
5 A. I believe it's just a duplication because my
6 recollection of the full form, it looks like the exact
7 same information that was on the previous exhibit.
8 **Q. Okay.**
9 **Let's look at the bottom here. And I think**
10 **you're probably right. The bottom, it says it was**
11 **printed on 5/19/2021. So back in May this was printed.**
12 **Do you know why this was printed back in May of 2021?**
13 A. That I would not know.
14 **Q. Next I have got Exhibit 7. Do you see that?**
15 A. Yes.
16 **Q. This is the same thing it appears.**
17 **Is that right?**
18 A. Yep. Yes.
19 **Q. Next I'm showing you Exhibit 8. Do you see**
20 **that?**
21 A. Yes.
22 **Q. And it shows an addendum typed in there. Do you**
23 **see that?**
24 A. Yes.

Page 113

1 **Q. Is all of that something you typed in?**
2 A. Yes.
3 **Q. And you typed it in on October 17, 2019?**
4 A. Yes.
5 **Q. Did you see the patient on this date?**
6 A. No.
7 **Q. Who did see the patient on that date?**
8 A. Laura Lynch.
9 **Q. And who is Laura Lynch?**
10 A. She's a physician assistant at the clinic.
11 **Q. Next I'm showing you Exhibit 9. Have you seen**
12 **this document before?**
13 A. Yes.
14 **Q. What is it?**
15 A. It's the progress note written by Laura Lynch on
16 October 15th, 2019, of PBJ.
17 **Q. And did you review these notes on the date of**
18 **service of 10/15/2019?**
19 A. It appears I reviewed these notes two days
20 afterwards.
21 **Q. Did you make any changes to Laura Lynch's ---**
22 **what she had put in?**
23 A. No.
24 **Q. Would that somehow be indicated if you had made**

Page 114

1 **any changes?**
2 A. Yes.
3 **Q. How would you notate that? Would that be simply**
4 **--- would you state that on the addendum?**
5 A. I would state that on the addendum.
6 **Q. And this was just a follow-up visit.**
7 **Is that right?**
8 A. Yes.
9 **Q. I'm now showing you Exhibit 11A. Do you see**
10 **that?**
11 A. Not yet.
12 **Q. I forgot to hit start. Let me know when you see**
13 **it.**
14 A. I see it.
15 **Q. This says --- have you seen this document**
16 **before?**
17 A. Yes.
18 **Q. The encounter date is March 16, 2020.**
19 **Right?**
20 A. Yes.
21 **Q. Encounter date means the date of the visit.**
22 **Correct?**
23 A. Yes.
24 **Q. And who is Taylor Rives?**

Page 115

1 A. She was one of the resident trainees with me
2 that day.
3 **Q. Now, it says under history of present illness,**
4 **second sentence, she has been followed for gender**
5 **dysphoria with desire to start hormone blockers, but was**
6 **[redacted] last visit. What does that mean?**
7 A. [redacted]
[redacted] [redacted].
9 **Q.** [redacted]
[redacted] [redacted]
[redacted] [redacted]
12 A. Generally it means first signs of puberty, which
13 is different ---.
14 VIDEOGRAPHER: You're cutting out again,
15 Doctor Montano.
16 THE WITNESS: Can you hear me now?
17 VIDEOGRAPHER: Yes.
18 ATTORNEY TRYON: Yes.
19 THE WITNESS: Can you repeat the question
20 that you couldn't hear my answer?
21 BY ATTORNEY TRYON:
22 **Q.** [redacted]
[redacted] [redacted]
[redacted] [redacted] [redacted].

Page 116

1 **Q. Such as what?**
2 A. Depending on sex, but for those assigned male at
3 birth, it would be testicular growth. And for those
4 assigned female at birth, it would be breast buds.
5 ---
6 (WHEREUPON, AN OFF RECORD DISCUSSION WAS HELD.)
7 ---
8 BY ATTORNEY TRYON:
9 **Q. Down lower it says therapist, she has not**
10 **started seeing a therapist yet. However, they have a**
11 **therapist in her town who specializes in gender**
12 **dysphoria. Mother is waiting to start therapy until**
13 **B[redacted] wants to start. Do you know who that therapist**
14 **was to be?**
15 A. No.
16 **Q. Is it normal to wait as long as BPJ and Heather**
17 **waited to start seeing a therapist?**
18 ATTORNEY JONES: Objection to form.
19 THE WITNESS: To answer your question,
20 it's not atypical for someone to wait to see a
21 therapist.
22 BY ATTORNEY TRYON:
23 **Q. Do your patients who have gender dysphoria**
24 **typically meet with a therapist before meeting with you?**

Page 117

1 A. Not always.
2 **Q. But sometimes?**
3 A. Yes.
4 **Q. During your discussions with BPJ and Heather**
5 **Jackson, did you discuss having a therapist prior to**
6 **this date of 3/16/2020?**
7 A. From my recollection, yes, because of my custom
8 and practice. But yes.
9 **Q. Why do you --- and I take it you recommend that**
10 **they talk to a therapist.**
11 **Is that true?**
12 ATTORNEY JONES: Objection to form.
13 ATTORNEY BLOCK: Same.
14 BY ATTORNEY TRYON:
15 **Q. Go ahead.**
16 A. To answer your question, it's my custom and
17 practice to always --- to recommend seeing a therapist
18 because gender affirmation can be very difficult for the
19 patient, so it's in order to get them support that they
20 need.
21 **Q. And did you recommend that in your first visit**
22 **with BPJ and Heather Jackson?**
23 A. From my recollection, yes.
24 **Q. And what was their response?**

Page 118

1 A. I do not recall what their response was.
2 **Q. Did you suggest any names?**
3 A. That I don't know.
4 **Q. Do you typically give your patients names of**
5 **therapists?**
6 A. Yeah, my --- yes, my custom and practice is I
7 actually consult our behavioral health team and then
8 they speak with our patients to help find a therapist if
9 they need one.
10 **Q. Next is Exhibit 11B. I'm sorry, I need to go**
11 **back to 11A for a moment. So under physical exam, do**
12 **you see that?**
13 A. Yes.
14 **Q. It shows a reference to BP and then also to BMI.**
15 **What is BMI?**
16 A. BMI is a measurement of the weight in ratio to
17 someone's height.
18 **Q. And why is that tracked?**
19 A. Because it helps determine if --- a patient
20 might be having difficulties with obesity if it's too
21 high of a number.
22 **Q. And BMI percentages are divided into categories**
23 **for comparison to similar populations.**
24 **Is that right?**

Page 119

1 A. Yes.
2 **Q. Is it important to compare people to the correct**
3 **grouping?**
4 ATTORNEY BLOCK: Objection to form.
5 ATTORNEY TRYON: Let me rephrase.
6 BY ATTORNEY TRYON:
7 **Q. Go ahead.**
8 A. No, you can rephrase the question, please.
9 **Q. Why are they divided into categories to compare**
10 **for comparison to similar populations?**
11 A. It helps create a normalized data to help
12 pediatricians in general to figure out if someone is
13 outside the typical range.
14 **Q. And they're dividing it between boys and girls.**
15 **Right?**
16 A. Yes.
17 **Q. And this one shows that BPJ was in the** [redacted]
[redacted]
19 **Right?**
20 A. Yes.
21 **Q.** [redacted]
[redacted]
[redacted]
[redacted]

Page 120

1 [redacted]
[redacted]
[redacted]
[redacted]
5 ATTORNEY JONES: Objection to form.
6 BY ATTORNEY TRYON:
7 **Q.** [redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
13 **Q. So in your opinion, should BPJ have been**
14 **compared on BMI with** [redacted]
[redacted]
16 ATTORNEY JONES: Objection, scope.
17 BY ATTORNEY TRYON:
18 **Q. Go ahead.**
19 A. There's a debate as to which ones to be used and
20 our --- at least in my practice, if this is something
21 pertinent, I will try to do both boys and girls and make
22 a comparison.
23 **Q. So you think for BPJ you should track BPJ on**
24 **both boy's and girl's charts?**

Page 121

1 ATTORNEY JONES: Objection, scope.
2 BY ATTORNEY TRYON:
3 **Q. Is that right?**
4 A. That's what I would do.
5 **Q. Well, this is your form. Can't you modify it to**
6 **do that?**
7 ATTORNEY JONES: Objection, scope, asked
8 and answered.
9 BY ATTORNEY TRYON:
10 **Q. Go ahead. You can answer.**
11 ATTORNEY JONES: I don't want to give a
12 speaking objection.
13 ATTORNEY TRYON: I'll give you a standing
14 objection on this.
15 THE WITNESS: Can you repeat the
16 question?
17 BY ATTORNEY TRYON:
18 **Q. Well, let me back up. Maybe I misunderstood**
19 **something. This form that you're --- that is being**
20 **filled out here, is this a form that you created?**
21 A. It's a template I created, yes.
22 **Q. So on the template, are you able to add an**
23 **additional category for BMI percentiles for girls as**
24 **well as boys?**

Page 122

1 A. No, I cannot.
2 **Q. Why not?**
3 A. Because that's not automatically populated based
4 on the chart and what is listed as the legal sex of the
5 child.
6 **Q.** [redacted]
[redacted lines 7–13]
14 **Q. Do you record that anywhere?**
15 A. Usually I do.
16 **Q. Where would you record that?**
17 A. I would record that somewhere near the physical
18 exam.
19 **Q. On the system in the --- in the notes that you**
20 **type in.**
21 **Is that right?**
22 A. To clarify, I would just type it in.
23 **Q. And then when it was printed out, if you had**
24 **done that, it would be in here.**

Page 123

1 **Right?**
2 A. Yes.
3 **Q. Okay.**
4 **And just so we're clear, I'm not trying to, you**
5 **know, trick you or anything, but it's not in this chart**
6 **for BPJ.**
7 **Correct?**
8 A. Yes.
9 **Q. Okay.**
10 **I'm now showing you Exhibit 37. Let me know**
11 **when you can see that.**
12 A. Yes.
13 **Q. So this is one of the documents that we just**
14 **received. So on page one it shows at the top chief**
15 **complaint and then it says orders. What does that mean?**
16 A. So the heading says telephone. So what it shows
17 is basically the conversation that was done on the
18 telephone. And in this case it would be the reason why
19 they called.
20 **Q. Okay.**
21 **In the last exhibit that we looked at, Exhibit**
22 **11A, it showed the encounter date of 3/16, which is the**
23 **same date of this document.**
24 **Right?**

Page 124

1 A. Yes.
2 **Q. Then under clinical notes it says Quest came**
3 **upstairs. Is Quest a person?**
4 A. Quest is a laboratory service.
5 **Q. It says Quest came upstairs and said they needed**
6 [redacted]**, since the patient is only**
7 **nine. I entered the correct estradiol script. What is**
8 [redacted]**?**
9 A. [redacted] is the measurement of
10 the female hormone, [redacted] And especially for those
11 who may not produce enough, that's the one that will
12 pick up smaller levels.
13 **Q. And then at the end of the sentence it has two**
14 **superscript things. One says LM.1M. What does that**
15 **mean?**
16 A. Based on the attribution key, it basically said
17 who wrote that note and how did they write that note.
18 **Q. So the M says manual. Does that mean it's typed**
19 **in manually?**
20 A. Yes.
21 **Q. So does that mean information to the left of**
22 **that superscript is --- was entered manually?**
23 A. Yes.
24 **Q. Why was a script written for BPJ for** [redacted]

Page 125

1 [redacted]
2 A. It was written because it was the part of the
3 baseline labs if we were to start this patient on
4 pubertal blockers.
5 **Q. This particular document was also from the March**
6 **2000 --- March 16, 2020, but this information was not in**
7 **the other document that we had received from that same**
8 **date. Can you explain to me why there's two separate**
9 **systems? It appears it's two separate systems for**
10 **visits on the same day. Is that how that works? I mean**
11 **can you clear it up for me?**
12 ATTORNEY JONES: Objection. Scope. You
13 know, he's not an IT.
14 ATTORNEY TRYON: I understand.
15 BY ATTORNEY TRYON:
16 **Q. I'm just trying to understand what information**
17 **you have on this that can help me out.**
18 A. That I would not know.
19 **Q. But you are familiar with this document.**
20 **Right?**
21 A. Yes.
22 **Q. Did you see this back in March of 2020?**
23 A. Yes, it was sent to me.
24 **Q. Electronically?**

Page 126

1 A. Yes.
2 **Q. I'm looking now at the third page of this**
3 **exhibit, and I look down and see where it says self**
4 **harm?**
5 A. Yes.
6 **Q. And then it says TR.2T in the superscript. What**
7 **does that mean?**
8 A. That I would not know.
9 **Q. Well, does the T --- well, TR is the person's**
10 **name, right, Taylor Rives or Rives (different**
11 **pronunciation), if you look at the top?**
12 ATTORNEY JONES: Objection, asked and
13 answered.
14 THE WITNESS: That could mean anything,
15 so I would not be able to know what that would mean.
16 BY ATTORNEY TRYON:
17 **Q. Well, these superscripts, have you seen these**
18 **before?**
19 A. No. It's not part of the medical record that I
20 have.
21 **Q. Well, now it's unclear to me when you --- are**
22 **you saying you haven't seen this document before. I**
23 **thought you said that you had. Can you clear that up**
24 **for me?**

Page 127

1 A. I have seen this document before, but I have
2 never seen it with those superscripts in it.
3 **Q. Okay.**
4 **So under self harm it says** ███
█ ███
6 **Is that right?**
7 A. Yes.
8 **Q. And then suicidality, what is suicidality?**
9 A. Suicidality is the desire to end one's own life.
10 **Q.** ███
██ ███
██ ███
██ █ ███
██ █ ███ **next page. Sorry, I don't have questions**
15 **on the next page. It will be the following page.**
16 **There's a notation of some information that it appears**
17 **you entered. It says I saw and examined the patient and**
18 **was present during the key portion of the E, slash, M**
19 **service. Did you type that in?**
20 A. Yes.
21 **Q. And what is E, slash, M service?**
22 A. Evaluation and management.
23 **Q. Now, a couple lines down it says reviewed adol**
24 **med note from 10/15/2019 and at the time the patient was**

Page 128

1 **still at** ███ **and then it has got a superscript there.**
2 **It says GM.2M. And if you look down below, it says GM.2**
3 **and it refers to you, your name, on 3/16/2020 at 10:58**
4 **a.m. Looking at that now, does that give you an**
5 **indication what that superscript means?**
6 A. Based on the attribution key it means that I
7 wrote that note --- or wrote that portion of the note.
8 **Q. And what would be the portion of the note to the**
9 **left of the superscription.**
10 **Right?**
11 A. Yes.
12 **Q.** ███
██ ███
██ ███
██ ███
██ ███
██ █ ███
██ █ ███
██ █ ███
██ ███
██ ███
██ █ ███
██ █ ███
24 **Q. Not to ask the obvious, but did BPJ say why BPJ**

Page 129

1 **was uncomfortable?**
2 A. Same reason why she came in, it's because she
3 doesn't like her own body.
4 **Q. Did she actually say that or are you just**
5 **projecting --- not projecting, but is that what you**
6 **think --- why she was uncomfortable?**
7 ATTORNEY JONES: Objection to form.
8 THE WITNESS: From my recollection, she
9 told me that. That's why we have a process in which we
10 cover her face, so she doesn't have to see the
11 examination being done.
12 BY ATTORNEY TRYON:
13 **Q. What do you cover her --- BPJ's face with?**
14 A. A gown, a patient gown.
15 **Q. Okay.**
16 **Exhibit 11B, have you seen this document**
17 **before?**
18 A. I can't see it right now.
19 **Q. Oh, that's because I didn't hit the right**
20 **button.**
21 ATTORNEY BLOCK: David, how much --- how
22 much longer do you think you have?
23 ATTORNEY TRYON: I'm guessing --- I think
24 within an hour.

Page 130

1 ATTORNEY BLOCK: It's been about two
2 hours since our last break. Is now a good time for
3 another one?
4 ATTORNEY TRYON: It works for me if
5 people want to do that.
6 ATTORNEY JONES: Do you want to take a
7 break?
8 THE WITNESS: Yes.
9 ATTORNEY JONES And can also go off the
10 record just about timing also, just so I can get an idea
11 of, you know, how much time ---?
12 ATTORNEY TRYON: So let's go off the
13 record.
14 VIDEOGRAPHER: Let me take us off then.
15 Going off the record. The current time reads 1:33 p.m.
16 OFF VIDEOTAPE
17 ---
18 (WHEREUPON, A SHORT BREAK WAS TAKEN.)
19 ---
20 ON VIDEOTAPE
21 VIDEOGRAPHER:
22 We're back on the record. The current
23 time reads 1:44 p.m.
24 BY ATTORNEY TRYON:

Page 131

1 **Q. Okay.**
2 **Exhibit 11, do you see that?**
3 A. Yes.
4 **Q. And this is from the encounter date of April 13,**
5 **2020.**
6 **Right?**
7 A. Yes.
8 **Q. And you've seen this document before?**
9 A. Yes.
10 **Q. It shows you at the top. Does that mean you are**
11 **the author of this document?**
12 A. Yes.
13 **Q. And everything in here is correct as far as you**
14 **can tell?**
15 ATTORNEY JONES: Objection to form.
16 THE WITNESS: I see no errors.
17 BY ATTORNEY TRYON:
18 **Q. Under it says review the labs with mom, F[redacted]**
[redacted]
[redacted]
[redacted]
22 **Q. And you had a lab done for that --- for those?**
23 A. Yes.
24 **Q. And what does that tell you?**

Page 132

1 A. So in this case it gives us the baseline in
2 terms of what their original levels are.
3 **Q. I'm sorry, original levels of those two**
4 **chemicals?**
5 A. Yes.
6 **Q. And then testosterone, is that a separate lab**
7 **test?**
8 A. Yes.
9 **Q. And this document does not show those levels.**
10 **Correct?**
11 A. Correct.
12 **Q. And the next word, estradiol, how do you**
13 **pronounce that?**
14 A. Estradiol.
15 **Q. Estradiol. And that was also a test that was**
16 **run?**
17 A. Yes.
18 **Q. [redacted]**
[redacted]
[redacted]
21 **Q. So on the next page, where it says we discussed**
22 **with B[redacted] and then it has that language, if I**
23 **understand correctly, that is basically template**
24 **language but you insert B[redacted] name.**

Page 133

1 **Is that right?**
2 A. Yes.
3 **Q. But you recall that you discussed those things**
4 **with BPJ and Heather Jackson?**
5 A. Yes.
6 **Q. So this is on April 13. I'm going to show you**
7 **another document from April 13, 2020. Let me know when**
8 **you see that.**
9 A. I can see that.
10 **Q. It is Exhibit 38?**
11 A. Yes.
12 **Q. Again, this is from the prior document, which**
13 **was Exhibit 11B. We received that some time ago.**
14 **Exhibit 38 we just received within the past week. It**
15 **looks like --- are these --- and you may have already**
16 **said you don't know, but are these from different**
17 **systems or different parts of the same system, if you**
18 **know?**
19 A. That I --- that I do not know.
20 **Q. You see at the top it says visit date,**
21 **4/13/2020.**
22 **Right?**
23 A. Yes.
24 **Q. And have you seen this document before?**

1 A. No --- I clarify. I reviewed that document the
2 night before but not in my electronic medical records.
3 **Q. Okay.**
4 **It says under progress notes, it has your name**
5 **and it says you are the author. What were you the**
6 **author of?**
7 A. I was the author of the progress note that I
8 wrote related to that visit on that date.
9 **Q. What do you see in this document, because I'm**
10 **not familiar with it, that you believe that you actually**
11 **input it into the system?**
12 A. Can you rephrase the question? I do not
13 understand.
14 **Q. Sure. There's a lot of information on here, a**
15 **lot of writing. And I'm trying to understand what**
16 **information you would have inputted into this that**
17 **appears on this document.**
18 ATTORNEY JONES: And can I interject real
19 quick. It appears, you know, yesterday, last night was
20 the first time we were made aware of these documents.
21 And after looking at these documents going to, you know,
22 we're using your Bates number WV 0031 and WV 0032 and
23 then looking at the page number of both of them, it
24 appears that a page is missing from the progress note.

1 I do not believe that Doctor Montano can accurately, you
2 know, answer this question based on this missing page.
3 ATTORNEY TRYON: Yeah. I will represent
4 to you, as far as I know, this is what we got. I don't
5 know why that page is missing. I don't know if it was
6 not copied correctly when it was sent to us. These are
7 the documents that we received just two days ago. I'm
8 not sure what the missing page is. But if we could just
9 find out what Doctor Montano knows about these two
10 particular pages, recognizing that there's a missing
11 page that nobody knows what's there.
12 THE WITNESS: So from I tell by looking
13 through the information, it feels like it was a
14 duplicate --- there are words and information that are
15 duplicated from the progress note that I wrote on that
16 same day.
17 BY ATTORNEY TRYON:
18 **Q. Okay.**
19 **The reference to the [redacted]**
[redacted] **[redacted], is that something**
21 **you would have inputted or someone else?**
22 A. That would be something I would have ordered and
23 then it would be reflected on that note.
24 **Q. When you order something, how does that actually**

1 **happen? Do you write a script on like one of the old**
2 **fashion pads and give it to somebody or tell somebody**
3 **and they inputted it into the system or do you actually**
4 **input it into the system like this?**
5 A. I electronically inputted it.
6 **Q. Okay.**
7 **Did you actually order it from the provider?**
8 A. Can you clarify that question?
9 **Q. Let me ask you a different question. Who's**
10 **Samantha Richard?**
11 A. She was a medical assistant that worked in our
12 clinic at that time.
13 **Q. Okay.**
14 **So this [redacted] [redacted] kit, is that something**
15 **that would be stocked in the clinic or has to be ordered**
16 **from the manufacturer or supplier?**
17 A. It has to be ordered from the manufacturer.
18 **Q. Do you know who actually ordered it from the**
19 **manufacturer?**
20 A. I did.
21 **Q. You did?**
22 A. Yes.
23 **Q. So you actually --- do you do that**
24 **electronically or do you make a phone call?**

1 A. I do that electronically.
2 **Q. Okay.**
3 **Then next on the next page of this exhibit,**
4 **which I recognize appears that there may be a missing**
5 **page in between, it refers to --- under instructions it**
6 **says we will first obtain a preauthorization of**
7 **[redacted] Authorization from whom?**
8 A. It would be authorization from the patient's
9 insurance company.
10 **Q. Next I'm showing you Exhibit 39. Let me know**
11 **when you see that.**
12 A. Yes.
13 **Q. And this is for --- the note is dated 5/5/2020.**
14 **Do you see that?**
15 A. Yes.
16 **Q. And have you seen this document before?**
17 A. I've seen the contents of that document but not
18 in that format.
19 **Q. Fair enough. Everything in this document seems**
20 **correct to you?**
21 ATTORNEY JONES: Objection to form.
22 BY ATTORNEY TRYON:
23 **Q. I think you can --- anybody who has access to it**
24 **can scroll through it on the screen, but I think you**

1 **have a hard copy of it as well.**
2 **Is that right?**
3 A. Yeah. Based on the interaction, I recall that
4 happening and that is correct.
5 **Q. Who is Alexis Hammond?**
6 A. She's one of the nurses who works at our clinic.
7 **Q. Lauren Machi is also a nurse at the clinic.**
8 **Is that right?**
9 A. Yes.
10 **Q. Do you remember a [redacted] [redacted] being delivered?**
11 A. No, I did not physically saw it delivered.
12 **Q. Was it --- did you do --- well, strike that.**
13 **On 6/15/2020 there was [redacted]**
14 **with BPJ.**
15 **Is that right?**
16 A. Yes.
17 **Q. And who performed that?**
18 A. I did.
19 **Q. Who else was present at that procedure?**
20 A. If I could see the procedure note it will help
21 me remember if anyone else helped me during that
22 procedure.
23 **Q. Okay.**
24 **I'm showing you Exhibit 40. Is that the**

1 **procedure note that you're referring to? This is the**
2 **only information that I've received for any visit on**
3 **6/15/2020.**
4 A. That was part of the note, but I do have a hard
5 copy here.
6 **Q. Yeah. It's several pages long.**
7 A. Yes.
8 **Q. It goes --- Bates stamp is WV 22 through WV 26.**
9 A. Yes, I can see that.
10 **Q. Okay.**
11 **Is this the note you were referring to?**
12 A. Yes.
13 **Q. And have you seen the information in this**
14 **document before?**
15 A. Yes.
16 **Q. And it shows under procedures that you're the**
17 **author of this.**
18 **Is that right?**
19 A. Yes.
20 **Q. And then down at the bottom it says P[redacted],**
21 **[redacted]k, P[redacted]-J[redacted] d[redacted]**
22 **[redacted]**
23 **Do you see that?**
24 A. Yes.

1 **Q. So [redacted],**
2 **is it?**
3 A. Correct.
4 **Q. Did you insert a [redacted] insert?**
5 A. No.
6 **Q. It says she has been counseled concerning the**
7 **risks, benefits and alternatives to [redacted] and she**
8 **especially understands that her menstrual periods are**
9 **expected to become irregular and unpredictable**
10 **throughout the time she is using the [redacted] She has**
11 **no contradictions to [redacted] Her questions have been**
12 **answered. She has fully reviewed the FDA approved**
13 **[redacted] consent brochure, has signed the consent form**
14 **and wishes to proceed with the insertion today. Did she**
15 **sign a [redacted] consent brochure consent form?**
16 A. No.
17 **Q. But this says that she --- that BPJ did?**
18 ATTORNEY BLOCK: David, can you change
19 the view of the document so the page you're reading from
20 is up on the screen?
21 ATTORNEY TRYON: I'm sorry. I thought
22 everyone could see this, could go through it. So it
23 goes from page one onto page two.
24 BY ATTORNEY TRYON:

1 **Q. So this says that BPJ signed the consent form**
2 **for the [redacted] insert. Are you now saying this note**
3 **is wrong?**
4 A. The note is a template I was forced to use and
5 that's why I put in parentheses [redacted] because it's
6 a very similar procedure. But the way the hospital set
7 this up that was the only template I used and would not
8 let me finish the note or bill the patient's insurance
9 if I do not use that note. So this was the best next
10 option for me to use.
11 **Q. How many [redacted] insertions do you do a year?**
12 ATTORNEY JONES: Objection.
13 THE WITNESS: That number I do not keep
14 track of.
15 BY ATTORNEY TRYON:
16 **Q. Well, it's many many.**
17 **Right?**
18 A. It's something I do ---.
19 **Q. I'm sorry, what?**
20 A. I do it commonly, yes.
21 **Q. And yet you don't have a template that allows**
22 **you to say you inserted a [redacted]?**
23 ATTORNEY JONES: Objection. Don't answer
24 that. We're not here to talk about any type of --- you

Page 142

1 know, his diagnosis is what it is and ---.
2 ATTORNEY TRYON: No, this is --- this is
3 very relevant.
4 ATTORNEY JONES: Well, I'm --- I'm
5 instructing him not to answer. He spoke to you about
6 this and he spoke to you why he inserted --- or why he
7 inserted the words the way he did. If there's any other
8 concern then, you know, that's to be taken up for --- at
9 another time, another thing. But this case is about BPJ
10 and essentially her inability to play sports.
11 ATTORNEY TRYON: This case is about BPJ
12 and BPJ's diagnosis and treatment, and I'm entitled to
13 ask these questions and I'm not going to debate it.
14 ATTORNEY JONES: Okay.
15 I'm instructing him not to answer. I
16 think this is going beyond the scope. He explained.
17 It's asked and answered. Keep moving.
18 BY ATTORNEY TRYON:
19 **Q. The next statement says procedure, [REDACTED]**
20 **insert. Do you see that?**
21 ATTORNEY JONES: Objection, form. It
22 also says [REDACTED] insertion.
23 BY ATTORNEY TRYON:
24 **Q. Do you see where I'm reading?**

Page 143

1 A. Yes.
2 **Q. Do you have the ability to modify the language**
3 **underneath where it says clinical notes?**
4 A. No, because it's a template.
5 **Q. And you cannot modify that template?**
6 A. Correct.
7 **Q. And you cannot insert your own clinical notes?**
8 A. I could ---.
9 ATTORNEY JONES: Objection to form.
10 THE WITNESS: Under procedure comments I
11 clarified that this is specifically for [REDACTED]
12 procedure.
13 BY ATTORNEY TRYON:
14 **Q. Can you show me what you're referring to?**
15 A. In the very bottom, where it says procedure
16 comments, I said that I specifically reviewed the risk
17 for [REDACTED] procedure and including those risks and
18 that they both understand and consented.
19 **Q. Where is that consent form?**
20 A. It's in the chart.
21 ATTORNEY TRYON: We would request that
22 consent form because we do not have it.
23 BY ATTORNEY TRYON:
24 **Q. Where it says [REDACTED] insert information, do**

Page 144

1 **you see that?**
2 A. Yes.
3 **Q. It says office supplied device and then it says**
4 **yes. Did the office supply that device?**
5 A. We had the device, correct.
6 **Q. And it shows the lot number.**
7 **Right?**
8 A. Yes.
9 **Q. What's that lot number?**
10 A. It's the identification of the [REDACTED] to know
11 which lot it came from.
12 **Q. I'm sorry?**
13 A. Continue. I apologize.
14 **Q. So is it the actual lot number for the item**
15 **which was inserted?**
16 A. Yes.
17 **Q. Down further under procedure details it says**
18 **blank, presumably the child's name, was given post**
19 **insertion instructions. She understands that [REDACTED]**
20 **must be removed at the end of three years and may be**
21 **removed sooner if she wishes. And it has your initials**
22 **and the superscript. Did you enter that data?**
23 A. That was part of the template, yes.
24 **Q. No, it's not part of the data --- the template I**

Page 145

1 **don't think because if you look down at the bottom under**
2 **attribution key, it says M for manual.**
3 **Right?**
4 A. Yes.
5 **Q. So it says GM.1M, so that means it was manually**
6 **inputted.**
7 **Right?**
8 A. Yes.
9 **Q. And it actually shows the exact date and time**
10 **when you inputted that information.**
11 **Right?**
12 A. Yes.
13 **Q. The [REDACTED] insert lasts for three years.**
14 **Right?**
15 A. Yes.
16 **Q. But the [REDACTED] insert does not.**
17 **Correct?**
18 A. Yes.
19 **Q. There's nothing on this entire form that has the**
20 **word [REDACTED] does it?**
21 A. I used the word [REDACTED] because that's the
22 generic name.
23 **Q. Let's go to the next page. Up at the top, on**
24 **the right, where it says status, do you see that?**

Page 146

1 A. Yes.
2 **Q. It says deleted by Montano, Gerald, D.O., at**
3 **6/15/2020, 9:33 a.m. What does that mean? What is that**
4 **referring to?**
5 A. That means that I deleted the note.
6 **Q. What note did you delete?**
7 A. The procedure note that you see in the exhibit
8 on that current page.
9 **Q. What did the note say that you deleted?**
10 A. The whole note was deleted.
11 **Q. Does the information --- are you saying the**
12 **document that I have before me was deleted?**
13 ATTORNEY JONES: Objection to form.
14 THE WITNESS: So this page, specific
15 page, was the one I deleted, not the page before.
16 BY ATTORNEY TRYON:
17 **Q. Why did you delete this page?**
18 A. Same reason why I have difficulty with the last
19 page, because it had incorrect information and I did not
20 want to represent that.
21 **Q. Where are you able to --- but it says deleted,**
22 **but it's still here.**
23 **Right?**
24 A. Yes.

Page 147

1 **Q. So why does it say deleted if it's still here?**
2 **I'm confused.**
3 ATTORNEY JONES: Objection to form.
4 THE WITNESS: That I cannot explain.
5 BY ATTORNEY TRYON:
6 **Q. Who else was present at this appointment?**
7 A. Based on the note and my recollection, it was
8 me, BPJ and mom.
9 **Q. I'm sorry. I couldn't hear that.**
10 A. Based on the note and my recollection, it would
11 be BPJ, me, and her mom.
12 **Q. So where it says names of all present during the**
13 **procedure there's three asterisks below that. What are**
14 **those three asterisks for?**
15 A. That --- that means that it's a blank template,
16 fill in the blank. The reason ---.
17 **Q. I couldn't hear that. Sorry?**
18 A. Those three asteriskses is a fill in --- is a
19 --- is a place where you can fill in that information.
20 However, that was left blank because I deleted that
21 note.
22 **Q. So there is information below which specifically**
23 **says blank Pepper-Jackson. So somebody typed in BPJ's**
24 **name.**

Page 148

1 **Right?**
2 A. As I can see, yes.
3 **Q. Is that you?**
4 A. It looks like I did.
5 **Q. It says desires [redacted] insertion. You could**
6 **have typed in right there desires [redacted] insertion, but**
7 **you didn't.**
8 **Right?**
9 ATTORNEY JONES: Objection. Again, if
10 you look at the top it says deleted by Gerald Montano.
11 He again explained why this was deleted.
12 BY ATTORNEY TRYON:
13 **Q. You could have typed that in if you wanted to.**
14 **Right?**
15 COURT REPORTER: Was there an answer? I
16 didn't hear. What was the answer?
17 ATTORNEY JONES: I told him not to answer
18 that and I said next question.
19 COURT REPORTER: Did he answer it?
20 ATTORNEY TRYON: So you told him not to
21 answer that?
22 ATTORNEY JONES: I did. He explained to
23 you already why he deleted it. If you look at this note
24 it says deleted by Gerald Montano, and he told you why

Page 149

1 he specifically deleted that portion of the note. I can
2 have the court reporter read it back to you.
3 ATTORNEY TRYON: Well, let's go back to
4 the prior page. Go back to page one. Oops, I'm on the
5 wrong document.
6 ATTORNEY BLOCK: Objection. Just, David,
7 for the scope of this deposition, this is about his
8 treatment of BPJ, not about their recordkeeping
9 practices.
10 ATTORNEY TRYON: Jacob, can you bring up
11 Exhibit 40 for me again, please? Somehow I've lost it.
12 VIDEOGRAPHER: Yes.
13 ATTORNEY JONES: I join on that last
14 objection.
15 VIDEOGRAPHER: Mr. Tryon, I need you to
16 stop sharing the one that you have. If you could hit
17 the stop button. Thank you. This is what I have for
18 Exhibit 40. Do you see that?
19 ATTORNEY TRYON: Yes.
20 BY ATTORNEY TRYON:
21 **Q. So at the bottom there you did not delete this**
22 **page or the following page.**
23 **Is that right?**
24 A. Yes.

Page 150

1 **Q. And you did enter that information, B**
2 **Pepper-Jackson desires, as indicated by that superscript**
3 **there.**
4 **Right?**
5 A. Can you refer ---?
6 **Q. Where it says --- at the very bottom there is a**
7 **blank, a redaction, and it says Pepper --- well, B**
8 **Pepper-Jackson --- well, the deletion, desires. You**
9 **inputted those words.**
10 **Right?**
11 A. The part, yes.
12 **Q. So you were able to insert insertion?**
13 A. Yes, they allow for comments.
14 ATTORNEY JONES: With, all due respect,
15 if you look at the blank Pepper-Jackson it's GM.1T. GM,
16 if you go to the attribution key on WV 0024 is Montano,
17 Gerald, and then 1T is template. So if we're doing what
18 you said before and you're going to the left, the blank
19 Pepper-Jackson is part of the template.
20 ATTORNEY TRYON: Okay.
21 BY ATTORNEY TRYON:
22 **Q. Help me out here. So blank Pepper-Jackson is in**
23 **the template, Mr. Montano?**
24 A. Yes, that's part of the procedure note. It

Page 151

1 automatically generates the name.
2 ATTORNEY JONES: And again, I just object
3 to this line of questioning. I mean ---.
4 ATTORNEY TRYON: I'm going to move on to
5 the next exhibit.
6 ATTORNEY JONES: Thank you.
7 BY ATTORNEY TRYON:
8 **Q. So sharing with you Exhibit 42. Let me know**
9 **when you can see that.**
10 A. Yes, I see that.
11 **Q. And I'm going to go to the third page of that**
12 **document. And if we look down you see the paragraph**
13 **that starts B Oh, there's a couple places. Under**
14 **history of present illness, the second paragraph, do you**
15 **see that?**
16 A. Yes.
17 **Q. And it says she wants to know when she can start**
18 **hormone therapy.**

And so do you have an idea --- did you
20 **already decide when BPJ can start hormone therapy at**
21 **that point?**
22 A. No.
23 **Q. Did you ever discuss a timeframe for that with**
24 **BPJ and Heather Jackson?**

Page 152

1 A. No.
2 **Q. How about a timeline for**

5 **Q. Then it said below recently her dad said**
6 **which caused distress. What do you remember about that**
7 **conversation?**
8 A. Exactly what it says there.
9 **Q. So you just remember that --- who told you that**
10 **dad said , Heather or BPJ?**
11 A. Heather.
12 **Q. And that caused distress to whom?**
13 A. That caused distress to B
14 **Q. And did B explain that?**
15 A. As you can see she wasn't present in that visit.
16 I was speaking solely to mom. So this is from mom's
17 point of view.
18 **Q. Yeah, thank you for pointing that out. Lastly,**
19 **it says she has not . Why would that be put**
20 **in there?**
21 ATTORNEY JONES: Real quick, I'm just
22 going to object to the --- to the form of the question.
23 You're asking him to interpret a note of his resident.
24 I mean, as a supervising physician, you know, there are

Page 153

1 some things, but you know some --- I'm just going to
2 object to the form of the question.
3 BY ATTORNEY TRYON:
4 **Q. Well, let's back up. Did you review the**
5 **information in this form?**
6 A. Yes.
7 **Q. And it says she had . Did you**
8 **review that?**
9 A. Yes.
10 **Q. And why did you let that stay in there?**
11 A. I do not recall.
12 **Q. I mean, it's impossible for**

16 **Q. I'll show you Exhibit 43. Have you seen this**
17 **document before --- oops, I need to start. Let me know**
18 **when you see that.**
19 A. Yes.
20 **Q. This is from May 17, 2021. And then the second**
21 **page is from 5/17/2021. And this shows under telephone**
22 **encounter that your name and author is your name. And**
23 **then it says, hi, scheduling team, can you please reach**
24 **out to this family to schedule a follow-up appointment**

Page 154

1 **with me.**
2 **Do you see that?**
3 A. Yes.
4 **Q. Why did you want to have a follow-up**
5 **appointment?**
6 A. It's routine practice to have the patient return
7 every three months once they're put on the puberty
8 blocker to make sure everything is going all right.
9 **Q. And did you have that follow-up appointment?**
10 A. It did not happen.
11 **Q. Do you know why?**
12 A. That I don't know why. They didn't make that
13 appointment.
14 **Q. Did you have --- forgive me if I don't get the**
15 **terminology correct. Did you recommend or prescribe any**
16 **further treatment for BPJ other than the [redacted]**
17 A. No.
18 **Q. I'm showing you Exhibit 45. First page is just**
19 **a confidential disclosure statement that came with these**
20 **documents when we received them. And then the next**
21 **three pages are for --- well, I don't know how to**
22 **characterize this, but they're dated 5 --- excuse me. I**
23 **can't even --- it looks like the active coverage is as**
24 **of 12/31/2021, so it looks like that's the date of this**

Page 155

1 **document but the problem listed --- yeah, so 12/31/2021.**
2 **Do you recognize this document?**
3 A. It looks like a duplicate of the previous
4 document.
5 **Q. Can you look through here and tell me if**
6 **everything in here looks to be correct?**
7 ATTORNEY JONES: Objection to form. What
8 --- just this page only?
9 ATTORNEY TRYON: No, all three pages. I
10 guess a total of --- after the first page, disclosure
11 statement, the rest of the document.
12 ATTORNEY JONES: So just so we're clear,
13 not going by the Bates --- well, we can go by the Bates.
14 It would be WV 002 through WV ---.
15 ATTORNEY TRYON: 0004.
16 ATTORNEY BLOCK: I'm just going to make
17 an objection to form. A lot of this information is
18 blank.
19 THE WITNESS: From what I'm reading in
20 the information here, this is all correct.
21 BY ATTORNEY TRYON:
22 **Q. I didn't hear you.**
23 A. From what I'm reading in the information here in
24 the exhibit they are correct.

Page 156

1 **Q. And I recognize there's some information that**
2 **does not appear here and I'm just asking you to be clear**
3 **about the information that does appear here. So does**
4 **that --- your answer remain the same?**
5 A. Yes.
6 **Q. Let me ask you one question under problem list,**
7 **where it says [redacted].**
8 **Do you see that?**
9 A. Yes.
10 ATTORNEY JONES: On WV 000 ---.
11 BY ATTORNEY TRYON:
12 **Q. Is this [redacted] and the answer is no?**
13 A. Yes, I see that.
14 **Q. So can you explain that to me? Does that mean**
15 **that gender dysphoria is not a chronic condition or does**
16 **it mean something else? I don't understand it.**
17 A. If I understand this completely, when you put in
18 the diagnosis in the chart, sometimes that would be
19 specific to that date only. So it doesn't list that as
20 chronic. That date is only specific to that date from
21 my understanding of how the electronic medical records
22 is listed.
23 ATTORNEY JONES: Again, objection to this
24 line of questioning. I'm not exactly sure if Doctor

Page 157

1 Montano was even the person filling out this part of the
2 form. So you're essentially asking him to interpret
3 what someone else put.
4 VIDEOGRAPHER: Mr. Tryon, you appear to
5 be muted. Mr. Tryon? Can everybody hear me?
6 THE WITNESS: I can hear you.
7 VIDEOGRAPHER: Okay.
8 I'm going to send him a message. Give me
9 one second.
10 ATTORNEY HARTNETT: This is Kathleen
11 Hartnett for the Plaintiff. Just for the record, the
12 volume is going in and out for a lot of people listening
13 to it. So whatever is happening to him may be what's
14 been happening to us sporadically throughout the
15 deposition.
16 VIDEOGRAPHER: Okay.
17 ATTORNEY TRYON: I got booted. I am
18 back. Can you guys hear me?
19 VIDEOGRAPHER: Yes. I just sent you a
20 chat message.
21 ATTORNEY TRYON: Okay.
22 VIDEOGRAPHER: Okay.
23 BY ATTORNEY TRYON:
24 **Q. I'm sorry. So my question that I was trying to**

Page 158

1 **ask, Doctor Montano, have you had any conversations ---**
2 **communications with BPJ or Heather Jackson since May 17,**
3 **2021?**
4 A. Yes ---.
5 **Q. I'm sorry?**
6 A. Yes.
7 **Q. And when was that?**
8 A. From my recollection, it would be sometime in
9 December of 2021.
10 **Q. And what was that communication?**
11 A. The communication, as I recall, was that the
12 lawyers for West Virginia wanted to talk to me regarding
13 her care, and I basically told them that they would need
14 to sign a release of information for them to speak with
15 those lawyers.
16 **Q. And that was a conversation with --- with**
17 **Heather Jackson or BPJ?**
18 A. With Heather Jackson.
19 **Q. And anything else discussed during that**
20 **conversation?**
21 A. No.
22 **Q. Any other conversations other than that since**
23 **May 2021?**
24 A. No.

Page 159

1 ATTORNEY TRYON: Well, give me just a
2 minute. I think I'm about finished here. Let me take a
3 quick break and I'll be back in just a moment.
4 VIDEOGRAPHER: Going off the record.
5 Current time is 2:34 p.m.
6 OFF VIDEOTAPE
7 ---
8 (WHEREUPON, A SHORT BREAK WAS TAKEN.)
9 ---
10 ATTORNEY TRYON: No further questions.
11 ON VIDEOTAPE
12 VIDEOGRAPHER: We're back on the record,
13 2:37.
14 ATTORNEY TRYON: Okay.
15 This is David Tryon. I'm back, and I
16 have no further questions. Doctor Montano, thank you
17 for your time. I appreciate it. And we would request a
18 copy of that consent form that was discussed earlier.
19 And my question is simply do I need to do anything
20 formal to request that or will this suffice, Mr. Jones?
21 ATTORNEY JONES: I would say just send me
22 an e-mail just so I have something hard copy. And then
23 I'll make the request and get that for you.
24 ATTORNEY TRYON: Great. I doubt anybody

Page 160

1 else has any questions, but ---.
2 ATTORNEY GREEN: This is Roberta Green,
3 WVSSAC. I have no questions.
4 ATTORNEY BLOCK: This is Josh Block for
5 Plaintiff. We don't have any questions, but we want to
6 make sure the transcript is marked confidential.
7 ATTORNEY CROPP: This is Jeff Cropp for
8 Harrison County Board of Education, Dora Stutler. We
9 don't have any questions.
10 ATTORNEY MORGAN: This is Kelly Morgan on
11 behalf of the West Virginia Board of Education and
12 Superintendent Burch. I don't have any questions.
13 ATTORNEY TRYON: Tim, you're muted.
14 ATTORNEY DUCAR: Thank you. Timothy
15 Ducar on behalf of the intervenor. We have no
16 questions.
17 ATTORNEY TRYON: I think that concludes
18 today's deposition, Mr. Montano. You have the right to
19 review this --- the transcript. I'm sure your client
20 --- your attorney will instruct you accordingly, whether
21 or not ---
22 ATTORNEY JONES: We'll read.
23 ATTORNEY TRYON: --- to read or waive.
24 ATTORNEY JONES: We will read.

Page 161

1 VIDEOGRAPHER: That concludes the
2 deposition.
3 ATTORNEY TRYON: I guess I didn't --- we
4 would like a copy of the transcript and that only, and
5 we would like an etranscript as well.
6 ATTORNEY DUCAR: Yes, the intervenor
7 would like a copy of the transcript as well. No video,
8 please.
9 VIDEOGRAPHER: That concludes the
10 deposition. The current time is 2:40 p.m.
11 * * * * * * *
12 CONFIDENTIAL VIDEOTAPED DEPOSITION CONCLUDED
13 AT 2:40 P.M.
14 * * * * * * *
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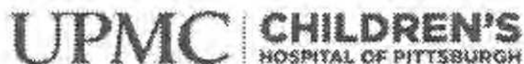

Patient: [redacted]
FIN: 0830827989196
MRN: 921765971 Male
DOB: [redacted]0
Age: 9 years

Adolescent Medicine-Evaluation

DOCUMENT NAME:	Adolescent Medicine-Evaluation
SERVICE DATE/TIME:	7/15/2019 10:04 EDT
RESULT STATUS:	Final
PERFORM INFORMATION:	MONTANO DO,GERALD (7/15/2019 10:05 EDT)
SIGN INFORMATION:	MONTANO DO,GERALD (7/18/2019 17:01 EDT)

Adolescent Medicine Outpatient Evaluation

Patient: [redacted] **MRN: 921765971** **FIN: 0830827989196**
Age: **9 years** Sex: **Male** DOB: [redacted]
Associated Diagnoses: **None**
Author: **MONTANO DO, GERALD**

History of Present Illness

CC: [redacted] (Legal Name: [redacted] is a 9 yo transgender female coming to the clinic for: gender dysphoria

History obtained from: [redacted] and her mother

HISTORY OF PRESENT ILLNESS
Incongruence
Identifies as transgender instead of male

Desire to be treated as other gender
Preferred pronouns: she/her
Preferred name: [redacted]

Desire to get rid of secondary sex characteristics
Expectations for today's visit: "stop boy hormones from kicking in during puberty"
Hopes for hormone therapy: puberty blocking

Desire for secondary sex characteristic of other gender/ to be other gender
Severity of wanting to be another gender is based on the following:
Hairstyle: y
Clothing: y
Shoes: y
Name: y
Been expressing herself as female: 1 year

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Patient:
FIN: 0830827989196
MRN: 921765971 Male
DOB:
Age: 9 years

Adolescent Medicine-Evaluation

Duration
Identified as transgender since: 3 years old

Context
Out to family: yes
Family Members: father, grandparents, siblings aunts/uncles
Family supportive: yes
Effect on puberty on gender identity: improves it

Histories

Past Medical History
There is no prior medical history.

Surgical History
There is no prior surgical history.

Family History
Family History
Father
CVA (cerebral vascular accident).: negative
Clotting disorder.: negative
Coronary artery disease.: negative
DVT - Deep vein thrombosis: negative
Pulmonary embolism

15-SEP-2015 23:29:21<$>: negative

Mother
CVA (cerebral vascular accident).: negative
Coronary artery disease.: negative
Clotting disorder.: negative
DVT - Deep vein thrombosis: negative
Pulmonary embolism

15-SEP-2015 23:29:21<$>: negative

Sibling
CVA (cerebral vascular accident).: negative
Clotting disorder.: negative
Coronary artery disease.: negative

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DVT - Deep vein thrombosis: negative
Pulmonary embolism

15-SEP-2015 23:29:21<$>: negative

Social History

Social & Psychosocial Habits

No Data Available.

A detailed psychosocial assessment was conducted and documented confidentially and relevant recommendations and health education was offered to the patient and family.

School very supportive with affirmation of [redacted] gender.

Objective

Allergies

No active allergies have been recorded..

Medications

None.

The patients vital signs and measurements are as documented

Vitals

07/15/2019 10:09		
	Systolic BP	99 mmHg
	Diastolic BP	61 mmHg
	BP Site	Right Arm
	BP Method	NIBP/monitor
	Flu Shot/Mist	No
	Weight	38.40 kg
	Dose Weight	38.40 kg
	Height	138.8 cm
	Body Surface Area	1.22 m2
	Body Mass Index	19.93 kg/m2
	BMI Percentile	91.29 .

Physical Examination

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Patient: [redacted]
FIN: 0830827989196
MRN: 921765971 Male
DOB: [redacted]
Age: 9 years

Adolescent Medicine-Evaluation

In general: The patient is well nourished, well developed and in no acute distress. . The patient was examined with Mother in room.

Eyes

Normal, no conjunctival injection or icterus. Pupils equal, round, reactive to light.

Ears

Tympanic membranes are normal bilaterally.

Mouth

Mucous membranes are moist. No oral lesions are noted.

Neck

No thyromegaly is noted. Neck has no masses.

Cardiovascular

Cardiovascular evaluation reveals a regular rate and rhythm, S1/S2 are normal, no murmur is appreciated. No edema is noted.

Respiratory

Lungs are clear to auscultation bilaterally. There are no crackles or wheezes. No increase in work of breathing is appreciated.

Gastrointestinal

The abdomen is soft, non-tender, non-distended. No hepatosplenomegaly is noted. Normal active bowel sounds were ascultated.

Genitourinary

- The patient's testicular size is 5 cc. Pubic hair is
  Tanner Stage 1: no pubic hair noted

  The penis is
  Tanner Stage 1: preadolescent

  The testes are
  Tanner Stage 1: Preadolescent

Impression and Recommendations

All Problems

Gender dysphoria in pediatric patient / SNOMED CT 154707011 / Confirmed

Recommendations

[redacted] is a 9 year-old transgender female

Diagnosis	Plan
Gender dysphoria	History suggests that [redacted] suffers from gender dysphoria. The World Professional Association for Transgender Health, the Endocrine Society, and

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Patient:
FIN: 0830827989196
MRN: 921765971 Male
DOB:
Age: 9 years

Adolescent Medicine-Evaluation

American Academy of Pediatrics, states that the best treatment for gender dysphoria is gender affirmation via social support, pubertal blockers, cross-s
hormones, and/or surgery.

We discussed with and her parent/caregiver the nature, effects, benefits, risks, irreversibility, and consequences of cross-hormone thera
especially the risk for infertility. We have also advised of the transgender services provided at Children's Hospital of Pittsburgh and offered a refer
to the fertility services at Magee Women's Hospital. and her parent/caregiver expressed understanding. I answered all pertinent questions.

She is not eligible for pubertal blockers due to current SMR. RTC in 3 - 6 months to re-evaluate.

Today's Orders

Discharge Plan

Discharge Plan-Details

1.) In 3 months, return to the clinic. Before then, you can take a look at her genitals, and if there is any question of pubic hair, please show up. If there is none, you may cancel the appointment for another 3 months.

2.) I will contact Dr. Murray in Morgantown, WV to determine if her clinic can give pubertal blockers.

3.) We will order the puberal blocker ONCE she show signs of puberty (i.e., pubic hair).. **Patient Education & Follow up**

Patient Education & Follow-up Instructions:: Adolescent Medicine Gender and Sexual Development Program Resources (Custom), GERALD MONTANO In 3 months 10/15/2019 GSDEV.

Thank you for the opportunity to participate in the care of your patient. Please do not hesitate to contact me with any questions

Sincerely,

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Gerald Montano, D.O.

Professional Services

Orders

Evaluation and Management:

Office Consult Level 3 - 99243 (Order Processing): 07/15/2019 10:51, Routine, Diagnosis Gender dysphoria in pediatric patient, Are you the service provider?, Are you the documenting provider?

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Patient Name

FIN: 830827989196 CHP MRN: 921765971

DOS 0?/15/2019 09 27 DOB
Cerner # 47754184 EPIC FIN 363380719

Medical Record Number

Birthdate

ADOLESCENT MEDICINE
CONFIDENTIAL PATIENT QUESTIONNAIRE

CHP 2102 11/12 Page 1 of 2

CONFIDENTIAL (Your answers will not be given out)

These questions will help us get to know you better. **Your answers will be seen only by your health care team.**

What is your given name/legal name?

What is your preferred name?

What is your preferred pronoun ~~(do you prefer being referred to as 'he' or 'she' or another way)?~~ She

Phone numbers where we could reach you confidentially Mom 770-546 5868

Who came with you to the clinic today? Mother

What would you like to talk about today?

Please check if you have questions or are worried about any of the following:

- ☐ Height/weight
- ☐ Diet/food/appetite
- ☐ Skin (rash, acne)
- ☐ Breasts
- ☐ Frequent or painful urination
- ☐ Discharge from penis/vagina
- ☐ Itch/odor/pain in penis or vagina
- ☐ Menstruation/periods
- ☐ Wet dreams/masturbation
- ☐ STDs
- ☐ HIV/AIDS
- ☐ Trouble sleeping
- ☐ Feeling tired a lot
- ☐ Sad or crying a lot
- ☐ Stress
- ☐ Anger/temper
- ☐ Relationships
- ☐ Sexual orientation
- ☐ Violence/abuse
- ☐ All of the above
- ☑ Other (explain) AFAB

Self

What three words best describe you? Kind / GIRL / Careful

What are you really good at? Video Games

If you could change one thing about your life or yourself, what would it be? to be a Girl

Health Profile

Family and Friends

Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ☐ No ☑ Yes

Do you have at least one friend who you really like and feel you can talk to? ☐ No ☑ Yes

School and Activities

How are your grades compared to last year? honor roll ☐ Better ☐ Worse ☑ Same

What physical activities do you do and how often? Cheerleading / Pom-Pom Class

Eating/Weight

Are you satisfied with your eating habits? ☐ No ☑ Yes

Do you ever eat in secret? ☑ No ☐ Yes

Do you spend a lot of time thinking about ways to lose weight? ☑ No ☐ Yes

In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ☑ No ☐ Yes

Continued on reverse

2102

Patient Name

Medical Record Number

Birthdate

ADOLESCENT MEDICINE
CONFIDENTIAL PATIENT QUESTIONNAIRE

CHP-2102 11/12 Page 2 of 2

Tobacco

Do you ever smoke cigarettes/cigars or chew tobacco? ☒ No ☐ Yes

Do any of your family or close friends ever smoke cigarettes/cigars or chew tobacco? ☒ No ☐ Yes

Alcohol and Drugs

Have you ever ridden in a car driven by someone (including yourself) who was 'high' or had been using alcohol or drugs? ☒ No ☐ Yes

Do you ever use alcohol or drugs to relax, feel better about yourself, or to fit in? ☒ No ☐ Yes

Do you ever use alcohol/drugs while you are by yourself, alone? ☒ No ☐ Yes

Does anyone in your family drink or take drugs so much that it worries you? ☒ No ☐ Yes

Development

Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ☐ No ☒ Yes

I am romantically and/or sexually attracted to boys ☐ No ☒ Yes

I am romantically and/or sexually attracted to girls. ☒ No ☐ Yes

Have you ever had oral, vaginal or anal sex? ☒ No ☐ Yes If yes

My sex partners are ☐ Male ☐ Female ☐ Both

Are you using a method to prevent pregnancy? ☐ No ☐ Yes

Which? ______

Did you and your partner use a condom the last time you had sex? ☐ No ☐ Yes

Have you ever been told by a doctor or nurse that you had a sexually transmitted infection? ☐ No ☐ Yes

Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? ☒ No ☐ Yes

Emotions

Over the past two weeks, how often have you been bothered by any of the following problems.

1. Little interest or pleasure in doing things?
   ☒ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed or hopeless?
   ☒ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Have you ever seriously thought about killing yourself? ☒ No ☐ Yes

Weapons/Violence/Safety

Do you or anyone you live with have a gun, rifle or other firearm? ☐ No ☒ Yes

In the past year, have you carried a weapon for protection? ☒ No ☐ Yes

Has someone you were going out with (like a boyfriend or girlfriend) ever hurt you on purpose (this can include physically hurting you, making you do sexual things you don't want to do, or making you feel bad about yourself)? ☒ No ☐ Yes

Are you worried about violence or your safety? ☒ No ☐ Yes

Adapted from the AMA GAPS Middle-Older Adolescent Questionnaire Please do not use, adapt or further modify this form without prior written permission from the AMA

Patient Signature ______ Date 7-15-19

Reviewed by ______ Date 7/15/19 Time 5:25p

HIM PROXY/ABSTRACT
200 LOTHROP STREET
PITTSBURGH PA 15213

MRN: 741825130, DOB: [redacted], Sex: M

Patient

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WV0001

HIM PROXY/ABSTRACT
200 LOTHROP STREET
PITTSBURGH PA 15213

MRN: 741825130, DOB: [redacted], Sex: M

Patient (continued)

Demographics

Name: [redacted]
Address: [redacted]
Date of birth: [redacted] Sex: Male Gender identity: Male
Email: [redacted] Home phone: [redacted] Work phone: 888-888-8888
Mobile: [redacted]

Relationships

Name	Relation to Patient	Phone Number
Jackson,Heather	Mother	Home: 770-546-5868

Active Coverages as of 12/31/2021

COMMERCIAL

Plan: THE HEALTH PLAN Group: 0180958202 Member: H19069073
Effective from: 5/3/2021 Subscriber: [redacted] Subscriber ID: H19069073

Problem List as of 12/31/2021

Problems last reviewed by Thompson, Kourtney on 2/4/2020 0847

Gender dysphoria *[last edited by Thompson, Kourtney on 2/4/2020 0847]*

Diagnosis: Gender dysphoria Noted on: 02/04/2020 Priority: High
Chronic: No

Allergies as of 12/31/2021

Allergies last reviewed by Richard, Samantha on 9/15/2020 0849 - Allergies Reviewed
No Known Allergies

Immunizations as of 12/31/2021

No documentation.

Current Medications

Medications

This report is for documentation purposes only. The patient should not follow medication instructions within.
For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Current Medications

Medications last reviewed by Richard, Samantha on 9/15/2020 0849

Histrelin (VANTAS) 50 mg (50 mcg/day) impl implant kit

Instructions: Inject 1 each into the skin once for 1 dose
Authorized by: Montano, Gerald, DO Ordered on: 4/13/2020
Start date: 4/13/2020 Quantity: 1 kit
Refill: No refills remaining

Vitals

Patient (continued)

Vitals (continued)

Vital Signs - Last Recorded — Most recent update: 9/15/2020 8:50 AM

BP	Pulse	Temp	Ht	Wt
115/45 (93 %/ 7 %)* (Site: Right Arm)	58	98.8 °F (37.1 °C)	4' 9.05" (144.9 cm) (75 %)†	100 lb (45.4 kg) (92 %)†

BMI
21.60 kg/m² (93 %)†

*BP percentiles are based on the 2017 AAP Clinical Practice Guideline for boys
†Growth percentiles are based on CDC (Boys, 2-20 Years) data

History as of 12/31/2021

Family History as of 12/31/2021

Family History as of 12/31/2021

No History of

Relationship: No History of
Name: —
Status: —
Age: —
Genetic Sex: —
Gender Identity: —
Father: —
Mother: —
Linked with: —
Comment: —
Fertility Status: —
Fertility Comment: —

Condition	Age of Onset	Comment
Deep Vein Thrombosis		
Heart attack		
Pulmonary Embolism		
Stroke		

Substance & Sexuality History as of 12/31/2021

Tobacco Use as of 12/31/2021

Smoking Status	Smoking Start Date	Smoking Quit Date	Packs/Day	Years Used
Never Smoker	—	—	—	—

Types	Comments	Smokeless Tobacco Status	Smokeless Tobacco Quit Date	Source
—	—	Never Used	—	Provider

Alcohol Use as of 12/31/2021

Alcohol Use	Drinks/Week	Alcohol/Week	Comments	Source
—		—	—	Provider

Drug Use as of 12/31/2021

Drug Use	Types	Frequency	Comments	Source

CONFIDENTIAL

HIM PROXY/ABSTRACT
200 LOTHROP STREET
PITTSBURGH PA 15213

MRN: 741825130, DOB: [redacted], Sex: M

Patient (continued)

History (continued) as of 12/31/2021

—	—	—	—	Provider

Sexual Activity as of 12/31/2021

Sexually Active	Birth Control	Partners	Comments	Source
—	—	—	—	Provider

Socioeconomic History as of 12/31/2021

Socioeconomic as of 12/31/2021

Marital Status	Spouse Name	Number of Children	Years Education	Education Level	Preferred Language	Ethnicity	Race	Source
Single	—	—	—	—	English	Not Hispanic or Latino	White	—

Advance Care Planning

Plan

Patient Capacity

The patient has full capacity. There is no history of patient status change.

Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
Not on file					

Surrogate Decision Makers

There are no Surrogate Decision Makers on file.

Patient Contacts

Patient Contacts

Name	Relationship	Phone	Roles
Jackson,Heather	Mother	[redacted]	

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

B.P.J., by her next friend and mother, HEATHER JACKSON,

Plaintiff,

v.

WEST VIRGINIA STATE BOARD OF EDUCATION, HARRISON COUNTY BOARD OF EDUCATION, *et al.*,

Defendants,

and

LAINEY ARMISTEAD,

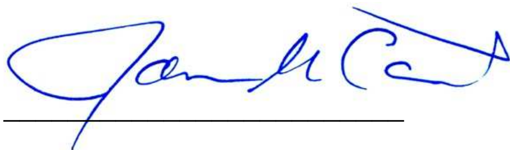
Defendant-Intervenor.

Civil Action No: 2:21-cv-00316

THE HONORABLE JOSEPH R. GOODWIN

DECLARATION OF JAMES M. CANTOR, PHD.

I, Dr. James Cantor, pursuant to 28 U.S. Code § 1746, declare under penalty of perjury under the laws of the United States of America that the facts contained in my Expert Report of James M. Cantor, Ph.D., in the Case of *B.P.J. v. West Virginia State Board of Education*, dated February 23, 2022, attached hereto, are true and correct to the best of my knowledge and belief, and that the opinions expressed therein represent my own expert opinions.



Dr. James M. Cantor, PhD.

Executed February 23, 2022

Expert Report of

James M. Cantor, PhD.

In the case of *B.P.J. vs. West Virginia State Board of Education*.

February 23, 2022

Table of Contents

I. Background & Credentials 1

II. Introduction 3

III. Clarifying Terms 4

IV. Evidence Cited by Plaintiffs' Expert Reports 5

V. Evidence Missing from Plaintiffs' Expert Reports 11

A. Adult-Onset Gender Dysphoria 12

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria 13

2. Mental Health Issues in Adult-Onset Gender Dysphoria 13

B. Childhood Onset (Pre-Puberty) Gender Dysphoria 15

1. Prospective Studies of Childhood-Onset Gender Dysphoria Show that Most Children Desist in the "Natural Course" by Puberty 15

2. "Watchful Waiting" and "The Dutch Approach" 18

3. Studies of Transition Outcomes: Overview 20

a. Outcomes of The Dutch Approach (studies from before 2017): Mix of positive, negative, and neutral outcomes 21

b. Clinicians and advocates have invoked the Dutch Approach while departing from its protocols in important ways. 23

c. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011. 24

4. Mental Health Issues in Childhood-Onset Gender Dysphoria 26

C. Adolescent-Onset Gender Dysphoria 28

1. Features of Adolescent-Onset Gender Dysphoria 28

2. Prospective Studies of Social Transition and Puberty Blockers in Adolescence 29

3. Mental Illness in Adolescent-Onset Gender Dysphoria 30

VI. Alleged Scientific Claims Assessed 32

A. Conversion Therapy 32

B. Claims that All Childhood Outcome Studies Are Wrong 33

C. Assessing Claims of Suicidality 34

D. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children. 37

E. Assessing the "Minority Stress Hypothesis" 41

VII. Assessing Statements from Professional Associations 42

A. Understanding the Value of Statements from Professional Associations 42

B. Misrepresentations of statements of professional associations. 43

1. World Professional Association for Transgender Health (WPATH) 44

2. Endocrine Society (ES) 45

3. Pediatric Endocrine Society and Endocrine Society (ES/PES) 46

4. American Academy of Child & Adolescent Psychiatry (AACAP) 47

5. American College of Obstetricians & Gynecologists (ACOG) 48

6. American College of Physicians (ACP) 49

7. American Academy of Pediatrics (AAP) 51

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group 51

References 53

I. Background & Credentials

1. I am a clinical psychologist and Director of the Toronto Sexuality Centre in Canada. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2. Over my academic career, my posts have included Psychologist and Senior Scientist at the Centre for Addiction and Mental Health (CAMH) and Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. My scientific expertise spans the biological and non-biological development of human sexuality, the classification of sexual interest patterns, the assessment and

treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment of treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. I have served as an expert witness in a total of 14 cases, which are listed in my *curriculum vitae*, attached here as Appendix 1, which includes a list of cases in which I have recently testified.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. I was a member of the hospital's adult forensic program. However, I was in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple projects.

7. For my work in this case, I am being compensated at the hourly rate of $400 per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

II. Introduction

8. The principal opinions that I offer and explain in detail in this report are:

a. Biological sex is a clear, scientifically valid, and well-defined category. The existence of disorders of sexual development in an extremely small proportion of individuals does not change this.

b. Neither early-onset (childhood) gender dysphoria nor adolescent-onset gender dysphoria can be assumed to reflect a fixed aspect of a person's psychological make-up or self-perception.

c. No study has demonstrated that "affirming" the transgender identity of a child or adolescent produces better mental health outcomes or reduced suicidality relative to psychotherapy and mental health support.

d. On the contrary, the contemporary studies have failed to find improved mental health in teens and young adults after administration of puberty blockers and/or cross-sex hormones.

e. e) Affirmation of a transgender identity in minors who suffer from early-onset or adolescent-onset gender dysphoria is not an accepted "standard of care."

In addition, I have been asked to provide an expert opinion on how relevant professional organizations have addressed these questions and whether any of them have taken any meritorious position that would undermine West Virginia's Protect Women's Sports Act (H.B. 3292) ("Act"). As I explain in detail in this report, it is my opinion that Plaintiffs' expert reports display a wide variety of flaws that call their conclusions into question and that no professional organization has articulated a meritorious position that calls into question the basis for the Act.

9. To prepare the present report, I reviewed the following resources related to this litigation:

a. West Virginia's Protect Women's Sports Act, H.B. 3293.

b. The Amended Complaint in this litigation.

c. Ms. Armistead's Declaration, Doc. 95-1.

d. Declaration and Expert Report of Deanna Adkins, MD.

e. Expert Report and Declaration of Joshua D. Safer, MD, FACP, FACE.

III. Clarifying Terms

10. Most scientific discussions begin with the relevant vocabulary and definitions of terms. In the highly polarized and politicized debates surrounding transgender issues, that is less feasible: Different authors have used terms in differing, overlapping ways. Activists and the public (especially on social media) will use the same terms, but to mean different things, and some have actively misapplied terms so that original documents appear to assert something they do not.

11. "Gender expression" is one such term. For another example, the word "child" is used in some contexts to refer specifically to children before puberty; in some contexts, to refer to children before adolescence (thus including ages of puberty); in still other contexts, to refer to people under the legal age of consent, which is age sixteen in the Netherlands (where much of the research was conducted) or age eighteen in much of North America. Thus, care should be taken in both using and interpreting the word "child" in this field.

12. Because the present document is meant to compare the claims made by others, it is the definitions used by those specific authors in those specific contexts which are relevant. Thus, definitions to my own uses of terms are provided where appropriate, but primarily explicate how terms were defined and used in their original contexts.

IV. Evidence Cited by Plaintiffs' Expert Reports

13. Dr. Adkins claimed a person's gender identity cannot be voluntarily changed. In actual clinical practice, that is rarely the relevant issue. The far more typical situation is youth who are *mistaken* about their gender identity. These youth are misinterpreting their experiences to indicate they are transgender, or they are exaggerating their descriptions of their experiences in service of attention-seeking or other psychological needs. Dr. Adkins' claim is not merely lacking any science to support it; the claim itself defies scientific thinking. In science, it is not possible to know that gender identity cannot be changed: We can know only that we lack evidence of such a procedure. In the scientific method, it remains eternally possible for evidence of such a treatment to emerge, and unlike sexual orientation's long history with conversion therapy, there have not been systematic attempts to change gender identity.

14. Dr. Adkins claimed that untreated gender dysphoria can result in several mental health issues, including suicidality. The relevant research on suicidality is summarized in its own section to follow. Nonetheless, Dr. Adkins' claim is a misleading half-truth: Missing is that people with gender dysphoria continue to experience those mental health symptoms even after they do transition, including a 19 times greater risk of death from suicide.[1] This is why clinical guidelines repeatedly indicate that mental health issues should be resolved *before* any transition, as indicated in multiple sets of clinical guidelines, summarized in their own section to follow. As emphasized even by authorities Dr. Adkins cites herself: Transition should not be relied upon itself to improve mental health status.

15. Adkins' support for the claim that untreated gender dysphoria lessens mental health consisted of two articles: Olson, *et al.* (2016) and Spack (2012). Such is a terrible misrepresentation of the state of the scientific literature. Although Olson,

[1] Dhejne, *et al.*, 2011.

et al., did indeed report that gender dysphoric children showed no mental health differences from the non-transgender control groups, Olson's report turned out to be incorrect. The Olson data were reanalyzed, and after correcting for statistical errors in the original analysis, the data instead showed that the gender dysphoric children under Olson's care *did,* in fact, exhibit significantly lower mental health.[2]

16. I conducted an electronic search of the research literature to identify any responses from the Olson team regarding the Schumm and Crawford re-analysis of the Olson data and was not able to locate any. I contacted Professor Schumm by email on August 22, 2021 to verify that conclusion, to which he wrote there has been: "No response [from Olson]."[3]

17. Adkins also misrepresented the views of Dr. Norman Spack. The article Adkins cited—Spack, 2012—repeatedly emphasized that children with gender dysphoria exhibit very many symptoms of mental illnesses. Spack asserted unambiguously that "Gender dysphoric children who do not receive *counseling* have a high risk of behavioural and emotional problems and psychiatric diagnoses."[4] The wording of Dr. Adkins' report ("gender dysphoria . . . if left untreated") misrepresents Spack so as to suggest Spack was advocating for medical transition to treat the gender dysphoria rather than counseling to treat suicidality and any other mental health issues. Moreover still, missing from Adkins' report was Spack's conclusion that "[m]ental health intervention should persist for the long term, even after surgery, *as patients continue to be at mental health risk, including for suicide.* While the causes of suicide are multifactorial, the possibility cannot be ruled out that some patients unrealistically believe that surgery(ies) solves their psychological distress."[5] Whereas

---

[2] Schumm & Crawford, 2020; Schumm, *et al.*, 2019.
[3] Schumm, email communication, Aug. 22, 2021 (on file with author).
[4] Spack, *et al.,* 2012, at 422, italics added.
[5] Spack, *et al.,* 2013, at 484, italics added

Adkins (selectively) cited Spack to support her insinuation that transition relieves distress, Spack instead explicitly warned against drawing exactly that conclusion.

18. Next, Adkins claimed to have achieved levels of success in her professional clinical practice unlike those reported by anyone anywhere else in the world: "All of my patients have suffered from persistent gender dysphoria, which has been alleviated through clinical appropriate treatment."[6] It is difficult to evaluate such a bold self-assessment of success. No clinic has published success rates even approximating this. By contrast, the peer-reviewed research literature repeatedly indicates that clients misrepresent themselves to their care-providers, engaging in "image management" so as to appear as having better mental health than they actually do.[7] In the absence of objective evidence, it is not possible to differentiate Adkins' claims of success from the simpler explanation that she and her patients are telling each other what they want and expect to hear.

19. Adkins referred to the clinical practice guidelines (CPG's) of three professional societies: the American Association of Pediatrics (AAP), the World Professional Association for Transgender Health (WPATH), and the Endocrine Society. This provides only an incomplete and inaccurate portrayal of the field. I am aware of six rather than three professional societies providing clinical guidelines for the care of gender dysphoric children. They are detailed more fully in their own section of this report. Nonetheless, with the broad exception of the AAP, their statements repeatedly noted:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.

[6] Adkins Report at 5.
[7] Anzani, *et al.*, 2020; Lehmann, *et al.*, 2021.

- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

20. Although Adkins referred to them as "widely accepted," the WPATH and the Endocrine Society guidelines have both been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation ("AGREE II") method, as part of an appraisal of all published CPGs regarding sex and gender minority healthcare.[8] Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research."[9] Neither the Endocrine Society's or WPATH's guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of "Do not recommend."[10]

21. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 2. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

[8] Dahlen, *et al.,* 2021.
[9] Dahlen, *et al.*, 2021, at 6.
[10] Dahlen, *et al.,* 2021, at 7.

22. Finally, the clinical guidelines from all these associations have become largely outdated. As detailed in the *Studies of Transition Outcomes* section of this report, there was some reason, circa 2010, to expect positive outcomes among children who transition, owing to optimistic findings reported from the Netherlands.[11] Early positive findings, however, have been retracted after statistical errors were identified,[12] or shown to be more attributable to mental health counseling rather than to medical transition.[13] The professional societies' statements were produced during that earlier phase.

23. In contrast with these U.S.-based associations, public healthcare systems throughout the world have instead been withdrawing their earlier support for childhood transition, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition. These have included Sweden[14, 15], Finland[16, 17], and the United Kingdom[18], and the Royal Australian and New Zealand College of Psychiatrists.[19]

24. Adkins repeatedly claimed success on the basis of what her patients tell her. In the absence of any systematic method, however, it is not possible to evaluate to what extent such a conclusion reflects human recall bias, cases of negative outcomes dropping out of treatment thus becoming invisible to Adkins, the aforementioned impression management efforts of clients, psychotherapy that they were receiving at the same time, or simple maturation during which the patients

[11] de Vries, et al., 2011.
[12] Kalin, 2020.
[13] c.f., Carmichael, *et al.,* 2021; Biggs, 2019; Biggs, 2020.
[14] Swedish Agency of Health Technology Assessment and Assessment of Social Services, 2019.
[15] Nainggolan, 2021.
[16] Finland Ministry of Social Affairs and Health, Council for Choices in Health Care, 2020, June 11.
[17] Finland Ministry of Social Affairs and Health, Council for Choices in Health Care, 2020, June 16.
[18] United Kingdom National Health Service (NHS), 2021, March 11.
[19] McCall, 2021.

would have experienced improved mental health regardless of transition. Indeed, the very purpose of engaging in systematic, peer-reviewed research instead of relating anecdotal recollections is to rule out exactly these biases.

25. Adkins referred to disorders of sexual development (DSDs) and intersex variations to claim that the very notion of there being two sexes is inherently flawed (*i.e.*, challenging "singular biological sex"). Although they both potentially involve medical alteration of genitalia, these are not comparable issues. DSDs and intersex conditions develop before birth, and objective medical testing is capable of confirming diagnoses. Her claims not only misrepresent the research literature on DSDs, but also failed to engage the relevant scientific concept, "construct validity." Adkins claimed DSD prevalences of 1 in 1000 live births and 1 in 300 people in the world (Adkins Report at 11), leaving unclear how there could be a larger proportion of such people living in the world than are born in the first place. The scientific literature, however, shows that DSDs are much rarer than this[20] and that the very large majority of DSDs are the hypospadias—mislocations of the urethra on the penis.[21] Because of the biological processes involved in causing them, hypospadias are classified as disorders of sexual development. That some boys are born with mislocated urethra is falsely taken by Adkins to demonstrate that 'there are more than just boys and girls'.

26. Overall, Adkins' argument was that, because there exist exceptions among features which distinguish male from female, the distinction itself is entirely moot. Although she did not use the term, Adkins is claiming that the existence of these exceptions demonstrates that sex lacks "construct validity." Her argument does not, however, follow from how construct validity is determined in science—very many scientific classification systems include exceptions. Scientific constructs are not

[20] Sax, 2002.
[21] Bancroft, 2009.

determined by any one of the components it reflects, in this case being each of the sex chromosomes, sex hormones, sexually dimorphic genitalia, etc. Rather, such constructs are represented by the generalizable interrelationships among its multiple components. Notwithstanding exceptions in an individual component in an individual case, the interrelationships among the network of components remains intact. The existence of people born with a clubfoot or undeveloped leg does not challenge the classification of humans as a bipedal species.

27. Similarly to Dr. Adkins, Dr. Safer claimed that "gender identity is durable and cannot be changed by medical intervention," providing no evidence or reference to the research literature. It is not at all apparent upon what basis such a statement about durability can be made, however. It has been the unanimous conclusion of every follow-up study of gender dysphoric children ever conducted, not only that gender identity does change, but also that it changes in the large majority of cases, as documented below. This is, of course, very different from what is reported by transgender adults—they are the very people for whom gender dysphoria did endure. Regarding responses to clinical intervention, I am not aware of, and Safer did not cite any research reports of medical interventions attempting to change gender identity, regardless of outcome. It is not clear whether Safer intended this comment to apply also to psychological/non-medical interventions.

V. Evidence Missing from Plaintiffs' Expert Reports

28. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria

(cases of *late-onset* gender dysphoria),[22] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD).

29. In the context of school athletics, the adult-onset phenomenon would not seem relevant; however, very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to the other. For example, there exist only very few cases of transition regret among adult transitioners, whereas the research has unanimously shown that the majority of children with gender dysphoria desist—that is, cease to experience such dysphoria by or during puberty. A brief summary of the adult-onset phenomenon is included, to facilitate distinguishing features which are unique to childhood gender dysphoria.

A. Adult-Onset Gender Dysphoria

30. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively male.[23] They typically report being sexually attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.[24] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.[25]

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22 Blanchard, 1985.
23 Blanchard, 1990, 1991.
24 Blanchard, 1988.
25 Blanchard 1989a, 1989b, 1991.

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria

31. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[26] Sweden,[27] and the Netherlands.[28]

32. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

33. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[29] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[30] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless concluded (1) that rates of mental health issues among people are highly elevated both before and after transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients

[26] Blanchard, *et al.*, 1989.
[27] Dhejneberg, *et al.*, 2014.
[28] Wiepjes, *et al.*, 2018.
[29] *See, e.g.*, Hepp, *et al.*, 2005.
[30] Dhejne, *et al.*, 2016.

becoming "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the available participants genuinely reflects the whole sample. The very high "lost to follow-up" rate leaves open the possibility of considerably more negative results overall.

34. An important caution applies to interpreting these results: These very high proportions of mental health issues come from people who are attending a clinic for the first time and are undergoing assessment. Clinics serving a "gate-keeper" role divert candidates with mental health issues away from medical intervention. The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

35. The long-standing and consistent finding that gender dysphoric adults have high rates of mental health issues both before and after transition and the finding that those mental health issues cause the gender dysphoria (the epiphenomenon) rather than the other way around indicate a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition. Mental health issues should be resolved before any transition.

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

1. Prospective Studies of Childhood-Onset Gender Dysphoria Show that Most Children Desist in the "Natural Course" by Puberty

36. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[31]

37. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. Projects following-up and reporting on such cases began being published in the 1970s, with subsequent generations of research employing increasingly sophisticated methods studying the outcomes of increasingly large samples. In total, there have now been a total of 11 such outcomes studies. *See* the appendix to Appendix 2 (listing these studies).

38. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoria are often called "persisters."

39. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: That is, it is not possible to know to what extent the observed outcomes (predominant desistance, with a small but consistent occurrence of persistence) were

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[31] Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.,* 2018; Wood, *et al.*, 2013.

influenced by the psychosocial support, or would have emerged regardless. It can be concluded only that prepubescent children who suffer gender dysphoria and receive psychosocial support focused on issues other than "affirmation" of cross-gender identification do in fact desist in suffering from gender dysphoria, at high rates, over the course of puberty.

40. While the absolute number of those who present as prepubescent children with gender dysphoria and "persist" through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, the clinician cannot take either outcome for granted.

41. It is because of this long-established and invariably consistent research finding that desistance is probable, but not inevitable, that the "watchful waiting" method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

42. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. Such is an empirical question, and there has not yet been any such study.

43. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can

be weighted. Such "risk prediction" and behavioral "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[32]

44. In contrast, a single research team, led by Dr. Kristina Olson, claimed the opposite, asserting to have developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[33] That team reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they described their result, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[34] Although the authors declared that "social transitions may be predictable from gender identification and preferences,"[35] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[36] Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. Thus, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

[32] Singh, *et al.* (2021); Steensma *et al.*, 2013.
[33] Rae, *et al.*, 2019, at 671.
[34] Rae, *et al.*, 2019, at 673.
[35] Rae, *et al.*, 2019, at 669.
[36] Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

45. Although it remains possible for some future finding to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probably of unnecessary transition and unnecessary medical risks.

2. "Watchful Waiting" and "The Dutch Approach"

46. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, often called "The Dutch Approach" (referring to The Netherlands clinic where it was developed) including "Watchful Waiting" periods. Internationally, the Dutch Approach is currently the most widely respected and utilized method for treatment of children who present with gender dysphoria.

47. The purpose of these methods was to compromise the conflicting needs among: clients' desires upon assessment, the long-established and repeated observation that those preferences will change in the majority of (but not all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

48. The Dutch Approach (also called the "Dutch Protocol") was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach* (de Vries & Cohen-Kettenis, 2012).

The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

49. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[37]

50. The age cut-offs of the Dutch Approach authors were not based on any research demonstrating their superiority over other potential age cut-off's. Rather, they were chosen to correspond to ages of consent to medical procedures under Dutch law. But whatever their original rationale, the data from this clinic simply contains no information about safety or efficacy of these measures at younger ages.

51. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents.

52. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Such children and families typically present with substantial distress involving both gender and non-gender issues. It is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly

[37] de Vries & Cohen-Kettenis, 2012, at 301.

seen by one of the clinic's psychologists or psychiatrists."[38] One is actively treating the person, while carefully "watching" the dysphoria.

53. The inclusion of psychotherapy and support during the watchful waiting period is, clinically, a great benefit to the gender dysphoric children and their parents. The inclusion of psychotherapy and support poses a scientific complication, however: It becomes difficult to know to what extent the outcomes of these cases might be related to receiving psychotherapy received versus being "spontaneous" desistance, which would have occurred on its own anyway. This situation is referred to in science as a "confound."

3. Studies of Transition Outcomes: Overview

54. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many authors have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. Seemingly contradictory findings are common in science with on-going research projects. When considered together, however, the full set of relevant reports show that a coherent pattern and conclusion has emerged over time, as detailed in the following sections. Initial optimism was suggested by reports of improvements in mental health.[39] Upon continued analysis, these seeming successes turned out to be illusory, however: The Bränström and Pachankis (2019) finding has been retracted.[40] The greater mental health among transitioners reported by Costa, *et al.* (2015) was noted to be because the control group consisted of cases excluded from hormone eligibility exactly because they showed poor mental health to begin with.[41] The improvements reported by the

[38] de Vries, *et al.*, 2011, at 2280-81.
[39] Bränström & Pachankis 2019; Costa, *et al.*, 2015; de Vries, *et al.*, 2011; de Vries, *et al.*, 2014.
[40] Kalin, 2020.
[41] Biggs, 2019.

de Vries studies from the Dutch Clinic themselves appear genuine; however, because that clinic also provides psychotherapy to all cases receiving puberty-blockers, it remains entirely plausible that the psychotherapy and not the puberty blockers caused the improvements.[42] New studies continued to appear an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health[43] or lack of improvement beyond psychotherapy alone,[44] and other studies continue to report on only the combined effect of both psychotherapy and hormone treatment together.[45]

a. Outcomes of The Dutch Approach (studies from before 2017): Mix of positive, negative, and neutral outcomes

55. The research confirms that some, but not all, adolescents improve on some, but not all, indicators of mental health and that those indicators are inconsistent across studies. Thus, the balance of potential benefits to potential risks differs across cases, and thus suggests different courses of treatment across cases.

56. The Dutch clinical research team followed up 70 youth undergoing puberty suppression at their clinic.[46] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[47]

57. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the

42 Biggs, 2020.
43 Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020.
44 Achille, *et al.*, 2020.
45 Kuper, *et al.*, 2020; van der Miesen, *et al.*, 2020, at 703.
46 de Vries, *et al.* 2011.
47 Biggs, 2020.

improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other, representing a confound. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[48]

58. The authors were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[49]

59. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[50] As those authors concluded, "Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence."[51] Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function), one cannot justify taking on the greater risks of social transition, puberty blockers or surgery

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48 de Vries, *et al*. 2011, at 2281.
49 de Vries, *et al*. 2011, at 2282, italics added.
50 Costa, *et al*., at 2212 Table 2.
51 Costa, *et al*., at 2206.

without evidence of such treatment producing superior results. Such evidence does not exist.

b. Clinicians and advocates have invoked the Dutch Approach while departing from its protocols in important ways.

60. The reports of partial success contained in de Vries, *et al.* 2011 called for additional research, both to confirm those results and to search for ways to maximize beneficial results and minimize negative outcomes. Instead, many other clinics and clinicians proceeded on the basis of the positives only, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, one and a half *years*[52]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

61. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[53] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

[52] de Vries, *et al.*, 2011.
[53] Tetelepta, 2021.

c. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011.

62. The indications of potential benefit from puberty suppression in at least some cases has led some clinicians to attempt to replicate the positive aspects of those findings. These efforts have not succeeded.

63. The Tavistock and Portman clinic in the U.K. recently released its findings, attempting to replicate the outcomes reported by the Dutch clinic.[54] Study participants were ages 12–15 (Tanner stages 3 for natal males, Tanner 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

64. A multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[55] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to "Endocrine Society Clinical Practice Guidelines."[56] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[57] (Although the authors reported detecting some improvements, these were only found when the large group undergoing cross-sex hormone treatment were added in.) Although the Dutch

[54] Carmichael, *et al.*, 2021.
[55] Kuper, *et al.*, 2020, at 5.
[56] Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.
[57] Kuper, *et al.*, 2020, at Table 2.

Approach includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[58]

65. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[59] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[60] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*."[61] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

66. In a recent update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[62] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors themselves noted, "The present study can, therefore, not provide

[58] Kuper, *et al.*, 2020, at 4.
[59] Achille, *et al.*, 2020, at 2.
[60] Achille, *et al.*, 2020, at 2.
[61] Achille, *et al.*, 2020, at 3 (italics added).
[62] van der Miesen, *et al.*, 2020, at 699.

evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[63]

67. It has not yet been determined why the successful outcomes reported by the Dutch child gender clinic a decade ago failed to emerge when applied by others more recently. It is possible that:

(1) The Dutch Approach itself does *not* work and that their originally successful results were a fluke;

(2) The Dutch Approach *does* work, but only in the Netherlands, with local cultural, genetic, or other unrecognized factors that do not generalize to other countries;

(3) The Dutch Approach itself *does* work, but other clinics and individual clinicians are removing safeguards and adding short-cuts to the approach, and those changes are hampering success.

(4) The Dutch Approach *does* work, but the cause of the improvement is the psychosocial support, rather than any medical intervention, which other clinics are *not* providing.

68. The failure of other clinics to repeat the already very qualified success of the Dutch clinic demonstrates the need for still greater caution before endorsing transition and the greater need to resolve potential mental health obstacles before doing so.

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

69. As shown by the outcomes studies, there is no statistically significant evidence that transition reduces the presence of mental illness among transitioners. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social

[63] van der Miesen, *et al.*, 2020, at 703.

isolation might develop hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

70. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but yet still retains the opportunity to do so later.

71. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.[64] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[65] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

72. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[66]

[64] Wallien, *et al.*, 2007.
[65] Cohen-Kettenis, *et al.*, 2003, at 46.
[66] Thrower, *et al.*, 2020.

Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[67] When two or more issues are present at the same time (in this case, gender dysphoria present at the same time as ADHD or ASD), researchers cannot distinguish when a result is associated with or caused by the issue of interest (gender dysphoria itself) or one of the side issues, called *confounds* (ADHD or ASD, in the present case).[68] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[69]

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

73. A third profile has begun to present to clinicians or socially, characteristically distinct from the previously identified ones.[70] Unlike adult-onset gender dysphoria (and also unlike childhood-onset, *see supra* Part IV.B.2), this group is predominately biologically female. This group first presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is this feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[71] The majority of cases appear to occur within clusters of peers and in association with increased social media use[72] and especially among people with autism or other neurodevelopmental or mental health issues.[73]

67 Thrower, *et al.*, 2020, at 703.
68 Cohen-Kettenis *et al.,* 2003, at 51; Skelly *et al.,* 2012.
69 Janssen, *et al.*, 2016.
70 Kaltiala-Heino, *et al.*, 2015; Littman, 2018.
71 Littman, 2018.
72 Littman, 2018.
73 Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

74. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a stigmatized minority, as some writers are quick to assume.[74] *See infra* Part VI.E (discussing the minority stress hypothesis). Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[75] Although long-term outcomes have not yet been reported, these distinctions argue against generalizing findings from the other types of gender dysphoria to this one. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to rapid-onset (aka adolescent-onset) gender dysphoria. That is, the group differences already observed argue against the conclusion that any given feature would be present, in general, throughout all types of gender dysphoria.

2. Prospective Studies of Social Transition and Puberty Blockers in Adolescence

75. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics systematically tracking and reporting on their case results) fail to distinguish between people who had childhood-

[74] Boivin, *et al.*, 2020.
[75] Biggs, 2020; Littman, 2018.

onset gender dysphoria and have aged into adolescence and people whose onset was not until adolescence. Similarly, there are clinics failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria. Studies selecting groups according to their current age instead of their ages of onset can produce only confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

76. In 2019, a Special Section of the *Archives of Sexual Behavior* was published: "Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[76] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[77] with suicide attempts ranging 10 to 45%.[78] Self-injurious thoughts and behaviors range 14–39%.[79] Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[80] Gender dysphoria also overlaps with Autism Spectrum Disorder.[81]

77. Of particular concern in the context of adolescent onset gender dysphoria is *Borderline Personality Disorder* (BPD). The DSM criteria for BPD are:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)

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[76] Janssen, *et al.*, 2019.
[77] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.
[78] Reisner, *et al.,* 2015.
[79] Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.
[80] de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.
[81] de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.

2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

78. It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria are actually cases of BPD.[82] That is, some people may be misinterpreting their experiences to represent a gender identity issue, when it instead represents the "identity disturbance" noted in symptom Criterion 3. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is substantially more common among biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people (*i.e.*, 0.02%). Thus, if even only a portion of people with BPD had an 'identity disturbance' that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.

79. A primary cause for concern is symptom Criterion 5: recurrent suicidality. Regarding the provision of mental health care, this is a crucial distinction: A person with BPD going undiagnosed will not receive the appropriate treatments (the

[82] *E.g.*, Zucker, 2019.

currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality. One would predict also that misdiagnoses would occur more often if one reflexively dismissed or discounted symptoms of BPD as responses to "minority stress." *See infra* Part VI.D (discussing minority stress).

80. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. *See infra* Part VI.C. The scientific concern presented by BPD is that it poses a potential confound: samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

VI. Alleged Scientific Claims Assessed

A. Conversion Therapy

81. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only rarely mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as shown unanimously by every follow-up study ever published. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is

mislabeled "conversion therapy."[83] Indeed, even actions of non-therapists, unrelated to any therapy have been labelled conversion therapy, including the very prohibition of biological males competing on female teams.[84]

B. Claims that All Childhood Outcome Studies Are Wrong

82. As already indicated, the follow-up studies of gender dysphoric children are unanimous in their conclusion that gender dysphoria desists in the large majority of cases. Nonetheless, some authors assert that the entire set of prospective outcomes studies on prepubescent children is wrong; that desistance is not, in fact, the usual outcome for gender dysphoric children; and that results from various retrospective studies are the more accurate picture.[85] As indicated in the responses published from authors of several prospective outcomes studies (and as summarized below), the detractors' arguments are invalid.[86]

83. There have been accusations that some of the prospective outcome studies are old. This criticism would be valid only if newer studies showed different results from the older studies; however, the findings of desistance are the same, indicating that age of the studies is not, in fact, a factor.

84. There have been accusations that some studies failed to use a DSM diagnosis, and should therefore be rejected. That would be a valid criticism only if studies using the DSM showed different results from studies not using the DSM. Because both kinds of studies showed the same results, one may conclude that DSM status was not a factor, even if using a DSM diagnosis would have been a preferred method.

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[83] D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior, 50,* 7–16.

[84] Turban, J. (2021, March 16). Trans girls belong on girls' sports teams. *Scientific American.* www.scientificamerican.com/article/trans-girls-belong-on-girls-sports-teams/

[85] Temple Newhook, *et al*., 2018; Winters, *et al*., 2018.

[86] Steensma, *et al*., 2018a; Zucker, *et al*. 2018.

85. There have been criticisms that some studies are too small to provide a reliable result. It is indeed true that if larger studies showed different results from the smaller studies, we would tend to favor the results of the larger studies. Because the smaller studies came to the same conclusion as the larger studies, however, the criticism is, once again, entirely moot.

86. There have been accusations that studies did not use the current DSM-5 as their method of diagnosing gender dysphoric children. This criticism would be valid only if there existed any studies using the DSM-5 against which to compare the existing studies. The DSM-5 is still too recent for there yet to have been long-term follow-up studies. It can be seen, however, that the outcome studies are the same across the DSM-III, DSM-III-R, DSM-IV, and DSM-IV-TR.

87. In science, there cannot be any such thing as a perfect study. Especially in medical research, where we cannot manipulate people in ways that would clear up difficult questions, all studies will have a fault. In science, we do not, however, reject every study with any identifiable short-coming—rather, we gather a diversity of observations, made with their diversity of compromises to safety and ethics (and time and cost, etc.), and tentatively accept the most parsimonious (simplest) explanation of the full set, weighting each study according to their individual strengths and weaknesses.

C. Assessing Claims of Suicidality

88. In the absence of scientific evidence associating improvement with transition among youth, demands for transition are increasingly accompanied by hyperbolic warnings of suicide should there be delay or obstacle to affirmation-on-demand. Social media circulate claims of extreme suicidality accompanied by declarations that “I’d rather have a trans daughter than a dead son.” Such claims convey only grossly misleading misrepresentations of the research literature, however.

89. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with differing clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[87] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified in "If you leave me, I will kill myself." Professing suicidality is also used for attention- seeking or for the support or sympathy it evokes from others, indicating distress much more frequently than an intent to die.

90. The scientific study of suicide is inextricably linked to that of mental illness. For example, as noted in the preceding, suicidality is a well-documented symptom of Borderline Personality Disorder (as are chronic identity issues), and personality disorders are highly elevated among transgender populations, especially adolescent-onset. Thus, the elevations of suicidality among gender dysphoric adolescents may not be a result of anything related to transition (or lack of transition), but to the overlap with mental illness of which suicidality is a substantial part. Conversely, improvements in suicidality reported in some studies may not be the result of anything related to transition, but rather to the concurrent general mental health support which is reported by the clinical reported prospective outcomes. Studies that include more than one factor at the same time without accounting for each other represent a "confound," and it cannot be known which factor (or both) is the one causing the effects observed. That is, when a study provides both mental health

[87] Freeman, *et al.,* 2017.

services and medical transition services at the same time, it cannot be known which (or both) is what caused any changes.

91. A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve upon transition and integration into an affirming environment. Dr. Adkins makes it explicit in her report that the purpose of "the medical treatment for gender dysphoria is to eliminate the clinically significant distress." (Adkins, p. 5.)

92. Despite that relevant professional association statements repeatedly call for mental health issues, including suicidality, to be resolved before transition (see *infra* Section VI), threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 19 studies of suicidality in gender dysphoria.[88]

93. Of particular relevance in the present context is suicidality as a well-documented symptom of Borderline Personality Disorder (BPD) and that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD. [See full DSM-5 criteria already listed herein.] That is, some people may be misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence and occurs in 2–3% of the

[88] McNeil, et al., 2017.

population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

94. Rates of completed suicide are elevated among post-transition transsexuals, but are nonetheless rare,[89] and BPD is repeatedly documented to be greatly elevated among sexual minorities[90]. Overall, rates of suicidal ideation and suicidal attempts appear to be related—not to transition status—but to the social support received: The research evidence shows that support decreases suicidality, but that transition itself does not. Indeed, in some situations, social support was associated with increased suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[91]

D. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children.

95. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

96. Referring to "affirmation" as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the

[89] Wiepjes, *et al.,* 2020.

[90] Reuter, *et al.,* 2016; Rodriguez-Seiljas, *et al.,* 2021; Zanarni, *et al.,* 2021.

[91] Bauer, *et al.*, 2015; Canetto, et al., 2021.

term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word "affirmation" refers to entirely different actions.

97. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

98. Formal clinical approaches to helping children expressing gender dysphoria employ a gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as "the affirmation approach." The most extreme decision-tree would be accurately called affirmation-*on-demand,* involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

99. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of "retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and

regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

100. Olson and colleagues employed exactly such a retrospective study. They offered their survey to children in the TransYouth Project—people who have socially transitioned, their families, and any contacts they had, by word of mouth. This method is referred to as "convenience sampling," and differs from genuinely representative samples in applying to means of ensuring study participants accurately represent the population being studied. There were three groups of children for comparison: (i) children who had already socially transitioned, (ii) their siblings, and (iii) children in a university database of families interested in participating in child development research. As noted by the study authors, "For the first time, this article reports on socially transitioned gender children's mental health as reported by the children."[92] Reports from parents were also recorded.[93] In contrast, no reports or ratings were provided by any mental health care professional or researcher at all. That is, although adding self-assessments to the professional assessments might indeed provide novel insights, this project did not add self-assessment to professional assessment. Rather, it replaced professional assessment with self-assessment. Moreover, as already noted, Olson's data did not show what the Olson team claimed.[94] The dataset was subsequently re-analyzed, and "[T]o the contrary, the transgender children, even when supported by their parents, had significantly lower average scores on anxiety and self-worth. "[95]

92 Durwood, *et al.*, 2017, at 121 (italics added).
93 *See* Olson, *et al.*, 2016.
94 Schumm, *et al.,* 2019.
95 Schumm & Crawford, 2020, p. 9

101. It is well established in the field of psychology that participant self-assessment can be severely unreliable for multiple reasons. For example, one well-known phenomenon in psychological research is known as "socially desirable responding"—the tendency of subjects to give answers that they believe will make themselves look good, rather than accurate answers. Specifically, subjects' reports that they are enjoying good mental health and functioning well could reflect the subjects' desire to be *perceived* as healthy and as having made good choices, rather than reflecting their actual mental health.

102. In their analyses, the study reported finding no significant differences between the transgender children, their non-transgender siblings, or the community controls. As the authors noted, "[t]hese findings are in striking contrast to previous work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety."[96] The authors are correct to note that their result contrasts with the previous research, but they do not discuss that this could reflect a problem with the novel research design they used: The subjective self-reports of the children and their parents' reports may not be reflecting reality objectively, as careful professional researchers would. Because the study did not employ any method to detect and control for participants indulging in "socially desirable responding" or acting under other biasing motivations, this possibility cannot be assessed or ruled out.

103. Because this was a single-time study relying on self-reporting, rather than a before-and-after transition study relying on professional evaluation, it is not possible to know if the children reported as well-functioning are in fact well-functioning, nor if so whether they are well-functioning because they were permitted to transition, or whether instead the fact is that they were already well-functioning

[96] Durwood, *et al.*, 2017, at 116.

and therefore permitted to transition. Finally, because the TransYouth project lacks a prospective design, it cannot be known how many cases attempted transition, reacted poorly, and then detransitioned, thus never having entered into the study in the first place.

E. Assessing the "Minority Stress Hypothesis"

104. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[97] The association is not entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

105. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

106. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with

[97] Meyer, 2003.

those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[98] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

VII. Assessing Statements from Professional Associations

A. Understanding the Value of Statements from Professional Associations

107. The value of position statements from professional associations should be neither over- nor under-estimated. In the ideal, an organization of licensed health care professionals would convene a panel of experts who would systematically collect all the available evidence about an issue, synthesizing it into recommendations or enforceable standards for clinical care, according to the quality of the evidence for each alternative. For politically neutral issues, with relevant expertise contained among association members, this ideal can be readily achievable. For controversial issues with no clear consensus, the optimal statement would summarize each perspective and explicate the strengths and weaknesses of each, providing relatively reserved recommendations and suggestions for future research that might resolve the continuing questions. Several obstacles can hinder that goal, however. Committees within professional organizations are typically volunteer activities, subject to the same internal politics of all human social structures. That is, committee members are not necessarily committees of experts on a topic—they are often committees of generalists handling a wide variety of issues or members of an interest group who feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

[98] Meyer, 2003.

108. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

B. Misrepresentations of statements of professional associations.

109. In the presently highly politicized context, official statements of professional associations have been widely misrepresented. In preparing the present report, I searched the professional research literature for documentation of statements from these bodies and from my own files, for which I have been collecting such information for many years. I was able to identify statements from six such organizations. Although not strictly a medical association, the World Professional Association for Transgender Health (WPATH) also distributed a set of guidelines in wide use and on which other organizations' guidelines are based.

110. Notably, despite that all these medical associations reiterate the need for mental health issues to be resolved before engaging in medical transition, only the AACAP members have medical training in mental health. The other medical specialties include clinical participation with this population, but their assistance in transition generally assumes the mental health aspects have already been assessed and treated beforehand.

1. World Professional Association for Transgender Health (WPATH)

111. The WPATH standards as they relate to prepubescent children begin with the acknowledgement of the known rates of desistance among gender dysphoric children:

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[99]

112. That is, "In most children, gender dysphoria will disappear before, or early in, puberty."[100]

113. Although WPATH does not refer to puberty blocking medications as "experimental," the document indicates the non-routine, or at least inconsistent availability of the treatment:

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre, van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).[101]

114. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families' decisions:

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[102]

115. It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[103]

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[99] Coleman, *et al.*, 2012, at 172.
[100] Coleman, *et al.*, 2012, at 173.
[101] Coleman, *et al.*, 2012, at 173.
[102] Coleman, *et al.*, 2012, at 176.
[103] Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).

2. Endocrine Society (ES)

116. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

117. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[104]

118. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome for any specific child."[105]

119. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues."[106] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

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[104] Hembree, *et al.*, 2017, at 3876.
[105] Hembree, *et al.*, 2017, at 3876.
[106] Hembree, *et al.*, 2017, at 3877.

120. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional."[107]

121. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes."[108]

3. Pediatric Endocrine Society and Endocrine Society (ES/PES)

122. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[109] Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.[110]

123. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[111] However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an

[107] Hembree, *et al.*, 2017, at 3872.
[108] Hembree, *et al.*, 2017, at 3877.
[109] PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.
[110] Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.
[111] Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

antiandrogen that directly suppresses androgen synthesis or action."[112] Despite the PES asserting it as "medically necessary," the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[113]

4. American Academy of Child & Adolescent Psychiatry (AACAP)

124. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

> Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[114]

125. The AACAP's language repeats the description of the use of puberty blockers only as an exception: "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues."[115]

126. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[116] adding that "[c]linicians should be aware of current evidence on the natural course of gender

[112] Hembree, *et al*. 2017, at 3883.
[113] Hembree, *et al*., 2017 at 3872, 3894.
[114] Adelson & AACAP, 2012, at 969.
[115] Adelson & AACAP, 2012, at 969 (italics added).
[116] Adelson & AACAP, 2012, at 963.

discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[117]

127. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[118] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[119]

128. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so."[120]

5. American College of Obstetricians & Gynecologists (ACOG)

129. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[121]

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[117] Adelson & AACAP, 2012, at 968.
[118] Adelson & AACAP, 2012, at 970 (italics added).
[119] Adelson & AACAP, 2012, at 969.
[120] Adelson & AACAP, 2012, at 969.
[121] ACOG, 2017, at 1.

130. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.[122]

131. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE),, PES, and the Endocrine Society—and by WPATH.[123] It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: "*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[124]

132. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[125] This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

133. ACOG's remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

6. American College of Physicians (ACP)

134. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including

[122] ACOG, 2017, at 1.
[123] ACOG, 2017, at 1, 3.
[124] ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).
[125] ACOG, 2017, at 3 Table 1.

nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services in public and private health benefit plans.[126]

135. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[127] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[128] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" does not include or reference research on gender identity.[129] Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T* persons."[130] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

136. There is another statement,[131] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[132] The document discusses medical transition procedures for adults rather than for children, except to note that "[n]o medical intervention is indicated for prepubescent youth,"[133] that a "mental health provider can assist the child and family with identifying an

[126] Daniel & Butkus, 2015a, 2015b.
[127] Daniel & Butkus, 2015b, at 2.
[128] Daniel & Butkus, 2015b, at 8 (italics added).
[129] APA, 2009 (italics added).
[130] Daniel & Butkus, 2015b, at 8 (italics added).
[131] Safer & Tangpricha, 2019.
[132] Safer & Tangpricha, 2019, at ITC1.
[133] Safer & Tangpricha, 2019, at ITC9.

appropriate time for a social transition,"[134] and that the "child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is higher than in their cisgender peers."[135]

7. American Academy of Pediatrics (AAP)

137. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.[136] Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.[137].

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group

138. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).[138] Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

139. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation

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[134] Safer & Tangpricha, 2019, at ITC9.
[135] Safer & Tangpricha, 2019, at ITC9.
[136] Cantor, 2020.
[137] Cantor, 2020, at 1.
[138] Carel et al., 2009.

and cannot be suggested routinely."[139] However, gender dysphoria was not explicitly mentioned as one of those other conditions.

[139] Carel et al. 2009, at 752.

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EXPERT REPORT OF JAMES M. CANTOR, PHD

APPENDIX 1

James M. Cantor, PhD

Toronto Sexuality Centre
2 Carlton Ave., suite 1820
Toronto, Ontario, Canada M5B 1J3

416-766-8733 (o)
416-352-6003 (f)
jamescantorphd@gmail.com

EDUCATION

Postdoctoral Fellowship Jan., 2000–May, 2004
Centre for Addiction and Mental Health • Toronto, Canada

Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Aug. 2013–Jun., 2018
Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
University of New England • Armidale, Australia

Assistant Professor Jun., 2005–Jun., 2010
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Sep., 2004–Jun., 2010
Clinical Psychology Residency Program
St. Joseph's Healthcare • Hamilton, Canada

PUBLICATIONS

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PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
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6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
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9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40*, 863–864. doi: 10.1007/s10508-011-9805-6
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11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26*, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment, 24.*

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment, 23,* 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicates for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 22,* 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 21,* 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research, 38,* 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 20,* 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print[Editorial]. *Archives of Sexual Behavior, 37,* 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior, 35,* 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: “Goin’ up” [Editorial]. *Archives of Sexual Behavior, 34,* 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior, 32,* 3–5.

FUNDING HISTORY

Principal Investigators: Doug VanderLaan, Meng-Chuan Lai
Co-Investigators: James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title: *Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency: Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds: $650,250 / 5 years (July, 2018)

Principal Investigator: Michael C. Seto
Co-Investigators: Martin Lalumière , James M. Cantor
Title: *Are connectivity differences unique to pedophilia?*
Agency: University Medical Research Fund, Royal Ottawa Hospital
Funds: $50,000 / 1 year (January, 2018)

Principal Investigator: Lori Brotto
Co-Investigators: Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title: *Investigations into the neural underpinnings and biological correlates of asexuality*
Agency: Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds: $195,000 / 5 years (April, 2017)

Principal Investigator: Doug VanderLaan
Co-Investigators: Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title: *Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency: Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds: $952,955 / 5 years (September, 2015)

Principal Investigator: James M. Cantor
Co-Investigators: Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title: *Neuroanatomic features specific to pedophilia*
Agency: Canadian Institutes of Health Research (CIHR)
Funds: $1,071,920 / 5 years (October, 2008)

Principal Investigator: James M. Cantor
Title: *A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency: Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds: $10,000 (July, 2008)

Principal Investigator:	James M. Cantor
Co-Investigator:	Ray Blanchard
Title:	*Morphological and neuropsychological correlates of pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review.* Plenary Session for the 40th Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
2. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
3. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests.* Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered.* Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, April 13). *The responses to* I, Pedophile *from We, the people.* Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to* I, Pedophile. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
8. Cantor, J. M. (2017, November 2). Pedophilia as a phenomenon of the brain: Update of evidence and the public response. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
9. Cantor, J. M. (2017, June 9). Pedophilia being in the brain: The evidence and the public's reaction. Invited presentation to *SEXposium at the ROM: The science of love and sex,* Toronto, Canada.
10. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion.* Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
11. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities.* Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
12. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction.* Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't.* Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: https://vimeo.com/239131108/3387c80652]
15. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research.* Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

16. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole.* Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
17. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World.* Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
18. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't.* Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
19. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process.* Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
20. Cantor, J. M. (2015, June). *Hypersexuality.* Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
21. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future.* Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
22. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles.* Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
23. Cantor, J. M. (2015, March. *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
24. Cantor, J. M. (2015, February). *Hypersexuality.* Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
25. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy.* Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
26. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society.* Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
27. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain.* Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
28. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications.* Invited lecture presented to the Mental Health and Addition Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
29. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor.* Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, April). *Pedophilia and the brain.* Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update.* Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
32. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.

33. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications.* Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
34. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia.* Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update.* Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we* do*?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
37. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications.* McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
38. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain.* Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
39. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy.* Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
40. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy.* Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
41. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art.* Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
42. Cantor, J. M. (2013, January). *Pedophilia and child molestation.* Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
43. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety.* Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
44. Cantor, J. M. (2012, November). *Pedophilia and brain research.* Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
45. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research.* Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
46. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend.* Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy.* Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men.* Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensberg, Germany.

49. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art.* Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
50. Cantor, J. M. (2010, October). *Manuscript publishing for students.* Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
51. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
52. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art.* Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
53. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
54. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
55. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men.* Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
56. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia.* Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
57. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles.* Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
58. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders.* Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
59. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model.* Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research.* Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles.* Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism.* Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI–2).* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI.* Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice.* Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis.* Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications.* Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research.* Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences.* Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging.* Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women.* Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies.* Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders.* Paper presented at the 26th annual meetingof the Association for the Treatment of Sexual Abusers, San Diego.
19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology.* Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma.* Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ–PIQ differences in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change…* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students.* Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders.* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2).* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention.* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females.* Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities.* Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior.* Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness.* Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review.* Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test.* Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayedi, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies.* Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V.* Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia.* Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia.* Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove. S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement.* Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnestic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment	Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression	Jan., 2010–Dec., 2021
Journal of Sex Research, The	Jan., 2008–Aug., 2020
Sexual Abuse: A Journal of Research and Treatment	Jan., 2006–Dec., 2019
Archives of Sexual Behavior	Jan., 2004–Present
The Clinical Psychologist	Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry
Annual Review of Sex Research
Archives of General Psychiatry
Assessment
Biological Psychiatry
BMC Psychiatry
Brain Structure and Function
British Journal of Psychiatry
British Medical Journal
Canadian Journal of Behavioural Science
Canadian Journal of Psychiatry
Cerebral Cortex
Clinical Case Studies
Comprehensive Psychiatry
Developmental Psychology
European Psychologist
Frontiers in Human Neuroscience
Human Brain Mapping
International Journal of Epidemiology
International Journal of Impotence Research
International Journal of Sexual Health
International Journal of Transgenderism
Journal of Abnormal Psychology
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Forensic Psychology Practice
Journal for the Scientific Study of Religion
Journal of Sexual Aggression
Journal of Sexual Medicine
Journal of Psychiatric Research
Nature Neuroscience
Neurobiology Reviews
Neuroscience & Biobehavioral Reviews
Neuroscience Letters
Proceedings of the Royal Society B (Biological Sciences)
Psychological Assessment
Psychological Medicine
Psychological Science
Psychology of Men & Masculinity
Sex Roles
Sexual and Marital Therapy
Sexual and Relationship Therapy
Sexuality & Culture
Sexuality Research and Social Policy
The Clinical Psychologist
Traumatology
World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, “Off the beaten track” grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean’s Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolin Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019 Local Host. Society for Sex Therapy and Research.

2015 Member, International Scientific Committee, World Association for Sexual Health.

2015 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers

2012–2013 Chair, Student Research Awards Committee, Society for Sex Therapy & Research

2012–2013 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers

2011–2012 Chair, Student Research Awards Committee, Society for Sex Therapy & Research

2010–2011 Scientific Program Committee, International Academy of Sex Research

2002–2004 Membership Committee • APA Division 12 (Clinical Psychology)

2002–2003 Chair, Committee on Science Issues, APA Division 44

2002 Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)

2001–2009 Reviewer • APA Division 44 Convention Program Committee

2001, 2002 Reviewer • APA Malyon-Smith Scholarship Committee

2000–2005 Task Force on Transgender Issues, APA Division 44

1998–1999 Consultant, APA Board of Directors Working Group on Psychology Marketplace

1997 Student Representative • APA Board of Professional Affairs' Institute on TeleHealth

1997–1998 Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns

1997–1999 Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges

1997–1999 Liaison • APA Committee for the Advancement of Professional Practice

1997–1998 Liaison • APA Board of Professional Affairs

1993–1997 Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
“TA of the Year Award,” from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times*.
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 Jul 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 Jul 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 Jun 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 Mar 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 Feb 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 Aug 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 Jun 2012. CNN Newsroom interview with Don Lemon. *CNN.*

LEGAL TESTIMONY, PAST 5 YEARS

2021	Cross et al. v Loudoun School Board	Loudoun, VA
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern District of New York, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, NY
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, NY
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada

EXPERT REPORT OF JAMES M. CANTOR, PHD

APPENDIX 2

Case 2:21-cv-00316 Document 305-3 Filed 05/12/22 Page 103 of 109 PageID #: 18967

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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

Toronto Sexuality Centre, Toronto, Canada

ABSTRACT
The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

CONTACT James Cantor jamescantorphd@gmail.com Toronto Sexuality Centre, 2 Carlton Street, suite 1820, Toronto, Ontario M5B 1J3, Canada.

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whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. … Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation,* while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268
47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders … will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

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Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

B.P.J., by her next friend and mother, HEATHER JACKSON,

Plaintiff,

vs.

WEST VIRGINIA STATE BOARD OF EDUCATION, et al.,

Defendants,

and

LAINEY ARMISTEAD,

Defendant-Intervenor.

Case No. 2:21-cv-00316

Hon. Joseph R. Goodwin

DECLARATION OF STEPHEN B. LEVINE, MD

I, Dr. Stephen B. Levine, pursuant to 28 U.S. Code § 1746, declare under penalty of perjury under the laws of the United States of America that the facts contained in my Expert Report of Stephen B. Levine, MD., in the Case of B.P.J. v. West Virginia State Board of Education, dated February 23, 2022 and attached hereto, are true and correct to the best of my knowledge and belief, and that the opinions expressed therein represent my own expert opinions.

Executed on February 23, 2022.

Stephen B. Levine, MD

Expert Report of

Stephen B. Levine, MD

In the case of B.P.J. vs. West Virginia State Board of Education.

February 23, 2022

TABLE OF CONTENTS

I. CREDENTIALS & SUMMARY 1

II. BACKGROUND ON THE FIELD 8

A. The biological baseline of the binary sexes 8

B. Definition and diagnosis of gender dysphoria 12

C. Impact of gender dysphoria on minority and vulnerable groups 13

D. Three competing conceptual models of gender dysphoria and transgender identity 14

E. Four competing models of therapy 16

III. THERE IS NO CONSENSUS OR AGREED "STANDARD OF CARE" CONCERNING THERAPEUTIC APPROACHES TO CHILD OR ADOLESCENT GENDER DYSPHORIA. 22

A. Experts and organizations disagree as to whether "distress" is a necessary element for diagnoses that justifies treatment for gender identity issues. 23

B. Opinions and practices vary widely about the utilization of social transition for children and adolescents. 24

C. The WPATH "Standards of Care" is not an impartial or evidence-based document. 25

D. Opinions and practices differ widely with respect to the proper role of psychological counseling before, as part of, or after a diagnosis of gender dysphoria. 28

E. Opinions and practices vary widely with respect to the administration of puberty blockers and cross-sex hormones. 30

IV. TRANSGENDER IDENTITY IS NOT BIOLOGICALLY BASED. 33

A. No theory of biological basis has been scientifically validated. 34

B. Large changes across time and geography in the epidemiology of transgender identification are inconsistent with the hypothesis of a biological basis for transgender identity. 35

C. Disorders of sexual development (or DSDs) and gender identity are very different phenomena, and it is an error to conflate the two. 38

D. Studies of individuals born with DSDs suggest that there may be a biological predisposition towards *typical* gender identifications, but provide no support for a biological basis for *trans*gender identification. 39

V. GENDER IDENTITY IS EMPIRICALLY NOT FIXED FOR MANY INDIVIDUALS. 40

A. Most children who experience gender dysphoria ultimately "desist" and resolve to cisgender identification. 40

B. Desistance is increasingly observed among teens and young adults who first manifest GD during or after adolescence. 42

VI. TRANSITION AND AFFIRMATION IS AN IMPORTANT PSYCHOLOGICAL AND MEDICAL INTERVENTION THAT CHANGES GENDER IDENTITY OUTCOMES. 45

A. If both a typical gender or a transgender long-term gender identity outcome are possible for a particular patient, the alternatives are not medically neutral. 45

B. Social transition of young children is a powerful psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance. 46

C. Administration of puberty blockers is a powerful medical and psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance on the historically observed timeline. 48

VII. TRANSITION AND AFFIRMATION ARE EXPERIMENTAL THERAPIES THAT HAVE NOT BEEN SHOWN TO IMPROVE MENTAL OR PHYSICAL HEALTH OUTCOMES BY YOUNG ADULTHOOD. 49

A. The knowledge base concerning therapies for gender dysphoria is "very low quality." 50

B. Youth who adopt a transgender identity show no durable improvement in mental health after social, hormonal, or surgical transition and affirmation. 52

C. Long-term mental health outcomes for individuals who persist in a transgender identity are poor. 54

VIII. TRANSITION AND AFFIRMATION DO NOT DECREASE, AND MAY INCREASE, THE RISK OF SUICIDE. 56

A. The risk of suicide among transgender youth is confused and exaggerated in the public mind. 56

B. Transition of any sort has not been shown to reduce levels of suicide. 58

C. Long-term life in a transgender identity correlates with very high rates of completed suicide. 59

IX. HORMONAL INTERVENTIONS ARE EXPERIMENTAL PROCEDURES THAT HAVE NOT BEEN PROVEN SAFE. 61

A. Use of puberty blockers has not been shown to be safe or reversible for gender dysphoria. 62

B. Use of cross-sex hormones in adolescents for gender dysphoria has not been shown to be medically safe except in the short term. 66

C. The timing of harms. 70

Bibliography 72

I. CREDENTIALS & SUMMARY

1. I am Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine, and maintain an active private clinical practice. I received my MD from Case Western Reserve University in 1967, and completed a psychiatric residency at the University Hospitals of Cleveland in 1973. I became an Assistant Professor of Psychiatry at Case Western in 1973, became a Full Professor in 1985, and in 2021 was honored to be inducted into the Department of Psychiatry's "Hall of Fame."

2. Since July 1973, my specialties have included psychological problems and conditions relating to individuals' sexuality and sexual relations, therapies for sexual problems, and the relationship between love, intimate relationships, and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research. I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five previously solo-authored books for professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book has a chapter titled "The Gender Revolution."

4. In total I have authored or co-authored over 180 journal articles and book chapters, 20 of which deal with the issue of gender dysphoria. I am an invited member of a Cochrane Collaboration subcommittee that is currently preparing a review of the scientific literature on the effectiveness of puberty blocking hormones and of cross-sex hormones for

gender dysphoria for adolescents. Cochrane Reviews are a well-respected cornerstone of evidence-based practice, comprising a systematic review that aims to identify, appraise, and synthesize all the empirical evidence that meets pre-specified eligibility criteria in response to a particular research question.

5. I first encountered a patient suffering what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic, and have served as Co-Director of that clinic since that time. Across the years, our Clinic treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric caregiver for several dozen of our patients and supervisor of the work of other therapists. I was an early member of the Harry Benjamin International Gender Dysphoria Association (later known as WPATH) and served as the Chairman of the committee that developed the 5th version of its Standards of Care. In 1993 the Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-Director.

6. In the course of my five decades of practice treating patients who suffered from gender dysphoria, I have at one time or another recommended or prescribed or supported social transition, cross-sex hormones, and surgery for particular patients, but only after extensive diagnostic and psychotherapeutic work.

7. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts asked me to serve as an independent, court-appointed expert in a litigation involving the treatment of a transgender inmate within the Massachusetts prison system. In that litigation, the U.S. Court of Appeals for the First Circuit in a 2014 (En Banc) opinion cited and relied on my expert

testimony. I have been retained by the Massachusetts Department of Corrections as a consultant on the treatment of transgender inmates since 2007.

8. In 2019, I was qualified as an expert and testified concerning the diagnosis, understanding, developmental paths and outcomes, and therapeutic treatment of transgenderism and gender dysphoria, particularly as it relates to children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-09887-S, 255th Judicial District, Dallas County, TX (the "*Younger* litigation"). I have provided expert testimony in other litigation as listed in my curriculum vitae. In 2019, I provided written expert testimony in the landmark case in the United Kingdom; *Bell v. The Tavistock and Portman NHS Foundation Trust*.

9. I am regularly requested to speak on the topic of gender dysphoria and have given countless presentations to academic conferences and Departments of Psychiatry around the country. In May of this year, I will be co-presenting a symposium on the management of adolescent-onset transgender identity at American Psychiatric Association's Annual Meeting.

10. A fuller review of my professional experience, publications, and awards is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

11. I am being compensated for my time spent in connection with this case at a rate of $400.00 per hour for consultation and $500.00 per hour for time spent testifying.

12. I have reviewed the "Declaration and Expert Report of Deanna Adkins, MD," dated January 21, 2022 ("Adkins"). In that declaration Dr. Adkins makes a variety of statements about gender dysphoria, therapies for gender dysphoria, and outcomes of therapies, which I believe to be inaccurate, or unsupported by scientific evidence. Dr. Adkins is a pediatric endocrinologist. I note with some concern that Dr. Adkins makes a number of sweeping and

purportedly scientific assertions but cites almost no peer-reviewed articles or studies that support her opinions.

13. Based on her declaration, Dr. Adkins' practice is focused on children and adolescents; her CV and declaration do not suggest substantial experience in working with adults or older young adults who are living in a transgender identity, or who suffer from gender dysphoria. (This diagnosis requires "clinically significant" distress.) The wider lifecycle view that derives from experience with these adults (and familiarity with the literature concerning them) provides an important cautionary perspective. The psychiatrist or psychologist treating a trans child or adolescent, of course seeks to make the young patient happy, but the overriding consideration is the creation of a happy, highly functional, mentally healthy person for the next 50 to 70 years of life. I refer to treatment that keeps this goal in view as the "life course" perspective.

14. Dr. Adkins' stated belief that the only way to avoid harm is affirmative care is just one of many questionable assumptions that lack firm scientific foundation. Others that frequently ride along with advocates' convictions about affirmative care include:

a. A trans identity is immutable;

b. Trans identities are primarily caused by biological forces;

c. Gender identity and orientation are distinct stable dimensions of identity;

d. There are no alternative treatments to affirmative care;

e. Affirmative care lastingly improves mental health and social function;

f. Affirmative care reduces the rates of suicidal ideation and suicide;

g. Young teens can give informed consent for hormones because they know best what will make them happy now and in the future;

h. De-transition of affirmed youth is rare;

i. Associated psychopathology during and after affirmative care is primarily due to minority stress.

15. These assertions are inaccurate or unsupported, for reasons that I explain in this Declaration. I will provide citations to published, peer-reviewed articles that inform my judgments.

16. I have also reviewed the "Expert Report and Declaration of Joshua D. Safer, MD," dated January 21, 2022 ("Safer"). In that declaration Dr. Safer similarly makes a variety of statements about gender dysphoria, therapies for gender dysphoria, and outcomes of therapies, which I believe to be inaccurate, or unsupported by scientific evidence. Dr. Safer also makes a number of sweeping and purportedly scientific assertions that are not substantiated by peer-reviewed articles or studies.

17. It is also my opinion that a number of Dr. Safer's assertions are inaccurate or unsupported, for reasons that I explain in this Declaration. Similarly, I will provide citations to published, peer-reviewed articles that inform my judgments.

18. A summary of the key points that I explain in this report is as follows:

a. Sex as defined by biology and reproductive function is clear, binary, and cannot be changed. While hormonal and surgical procedures may enable some individuals to "pass" as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex. (Section II.A.)

b. The diagnosis of "gender dysphoria" encompasses a diverse array of conditions, with widely differing pathways and characteristics depending on age of onset, biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.)

c. Among practitioners in the field, there are currently widely varying views concerning both the causes of and appropriate therapeutic response to gender dysphoria in children or adolescents. There are no generally accepted "standards of care" and existing studies do not provide a basis for a scientific conclusion as to which therapeutic response results in the best long-term outcomes for affected individuals. (Section III.)

d. Transgender identity is not biologically based. Rather, gender dysphoria is a psychiatric condition that cannot be identified by any biological test or measurement. (Sections IV.A, IV.B.)

e. Disorders of sexual development ("DSDs") are biological phenomena. It is an error to conflate and/or scientifically link DSDs with incidents of gender dysphoria. (Sections IV.C, IV.D.)

f. The large majority of children who are diagnosed with gender dysphoria "desist"—that is, their gender dysphoria does not persist—by puberty or adulthood. Desistance is also increasingly observed among teens and young adults who have experienced "rapid onset gender dysphoria" — first manifesting gender dysphoria during or shortly after adolescence. (Section V.A., V.B.)

g. "Social transition" —the active affirmation of transgender identity—in young children is a powerful psychotherapeutic intervention that will substantially reduce the

number of children "desisting" from transgender identity. Therefore, the profound implications of "affirmative" treatment—which include taking puberty blockers and cross-sex hormones—must be taken into account where social transition is being considered. (Section VI.A,, VI.B.)

h. Administration of puberty blockers is not a benign "pause" of puberty, but rather a powerful medical and psychotherapeutic intervention that almost invariably leads to persistence in a transgender identity and, ultimately, to the administration of cross-sex hormones. (Section VI.C.)

i. The knowledge base concerning the "affirmative" treatment of gender dysphoria available today has very low scientific quality with many long-term implications remaining unknown. (Section VII.A)

j. There are no studies that show that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes, as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population. This is true before and after transition, hormones, and surgery. (Section VII.B., VII.C.)

k. In light of what is known and not known about the impact of affirmation on the incidence of suicide, suicidal ideation, and other indicators of mental and physical health, it is scientifically baseless, and therefore unethical, to assert that a child or adolescent who express an interest in a transgender identity will kill him- or herself unless adults and peers affirm that child in a transgender identity. (Section VIII.)

l. Hormonal interventions to treat gender dysphoria are experimental in nature and have not been shown to be safe, but rather put an individual at risk of a wide range of long-term and even life-long harms including: physical health risks; sterilization and the associated emotional response; impaired sexual response; surgical complications and life-long after-care; alienation of family and romantic relationships; elevated mental health risks of depression, anxiety, and substance abuse. (Section IX.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of the binary sexes

19. Dr. Adkins asserts that "the terms biological sex and biological male or female are imprecise and should be avoided." (Adkins at 10.) Dr. Safer further asserts that the term biological sex "can cause confusion," and moreover that a person's sex encompasses gender identity. (Safer at 6.) These statements are untrue. Biological sex is very well defined in all biological sciences including medicine. It is pervasively important in human development throughout the lifecycle.

20. Sex is not "assigned at birth" by humans visualizing the genitals of a newborn; it is not imprecise. Rather, it is clear, binary, and determined at conception. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. As physicians know, sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. A publication of the federal government's National Institute of Health accurately summarizes the scientific facts:

> "Sex is a biological classification, encoded in our DNA. Males have XY chromosomes, and females have XX chromosomes. Sex makes us male or female. Every cell in your body has a sex—making up tissues and organs, like your skin, brain, heart, and

> stomach. Each cell is either male or female depending on whether you are a man or a woman." (NIH 2022.)

21. The binary of biological sex is so fundamental and wide-ranging in its effects on human (and mammal) development and physiology that since 2014 the NIH has required all funded research on humans or vertebrate animals to include "sex as a biological variable" and give "adequate consideration of both sexes in experiments." (NIH 2015). In 2021, the Endocrine Society issued a position paper elaborating on the application of the NIH requirement. The Endocrine Society correctly stated that "Sex is a biological concept . . . all mammals have 2 distinct sexes;" that "biological sex is . . . a fundamental source of intraspecific variation in anatomy and physiology;" and that "In mammals, numerous sexual traits (gonads, genitalia, etc.) that typically differ in males and females are tightly linked to each other because one characteristic leads to sex differences in other traits." (Bhargava et al. 2021 at 221, 229.)

22. The Endocrine Society emphasized that "The terms sex and gender should not be used interchangeably," and noted that even in the case of those "rare" individuals who suffer from some defect such that they "possess a combination of male- and female-typical characteristics, those clusters of traits are sufficient to classify most individuals as either biologically male or female." They concluded, "Sex is an essential part of vertebrate biology, but gender is a human phenomenon. Sex often influences gender, but gender cannot influence sex." (Bhargava et al. 2021 at 220-221, 228.) For purposes of this litigation, Dr. Bhargava's statement that gender cannot influence sex is of central importance.

23. As these statements and the NIH requirement suggest, biological sex pervasively influences human anatomy, its development and physiology. This includes, of course, the development of the human brain, in which many sexually dimorphic characteristics have now been identified. In particular, the Endocrine Society and countless other researchers have

determined that human brains undergo particular sex-specific developmental stages during puberty. This predictable developmental process is a genetically controlled coordinated endocrine response that begins with pituitary influences leading to increases in circulating sex hormones. (Bhargava et al. 2021 at 225, 229; Blakemore et al. 2010 at 926-927, 929; NIH 2001.).

24. Humans have viewed themselves in terms of binary sexes since the earliest historical records. Recognizing a concept of "gender identity" as something distinct from sex is a rather recent innovation whose earliest manifestations likely began in the late 1940s. Its usage became common in medicine in the 1980s and subsequently in the larger culture. Definitions of gender have been evolving and remain individual-centric and subjective. In a statement on "Gender and Health," the World Health Organization defines "gender" as "the characteristics of women, men, girls and boys that are socially constructed" and that "var[y] from society to society and can change over time," and "gender identity" as referring to "a person's deeply felt, internal and individual experience of gender." (WHO Gender and Health.) As these definitions indicate, a person's "felt" "experience of gender" is inextricably bound up with and affected by societal gender roles and stereotypes—or, more precisely, by the affected individual's *perception* of societal gender roles and stereotypes and their personal idiosyncratic meanings. Typically, gendered persons also have subtly different, often idiosyncratic, reactions to societal gender roles and stereotypes without preoccupation with changing their anatomy.

25. Thus, the self-perceived gender of a child begins to develop along with the early stages of identity formation generally, influenced in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show awareness of the two possibilities. As acceptance of the designated

gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Is it a product of the quality of early life caregiver attachments? Does it stem from trauma-based rejection of maleness or femaleness, and if so, flowing from what trauma? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition (autism)? The answers to these relevant questions are not scientifically known but are not likely to be the same for every trans-identified child, adolescent, or adult.

26. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop postnatally, culminating in the dramatic maturation of the primary and secondary sex characteristics with puberty. These include differences in hormone levels, height, weight, bone mass, shape, musculature, body fat levels and distribution, and hair patterns, as well as physiological differences such as menstruation and ejaculation. These are genetically programmed biological consequences of sex—the actual meaning of sex over time. Among the consequences of sex is the consolidation of gender identity during and after puberty.

27. Despite the increasing ability of hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes, including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally defined sex. For instance, the XX (genetically female) individual who takes testosterone to stimulate certain male secondary sex characteristics will nevertheless remain

unable to produce sperm and father children. It is certainly true, as Dr. Adkins writes, that "[h]ormone therapy and social transition significantly change a person's physical appearance." (Adkins at 8.) But in critical respects this change can only be "skin deep." Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a complete man" or "a complete woman," this is not biologically attainable. (Levine 2018 at 6; Levine 2016 at 238.) It is possible for some adolescents and adults to pass unnoticed—that is, to be perceived by most individuals as a member of the gender that they aspire to be—but with limitations, costs, and risks, as I detail later.

B. Definition and diagnosis of gender dysphoria

28. Specialists have used a variety of terms over time, with somewhat shifting definitions, to identify and speak about a distressing incongruence between an individual's genetically determined sex and the gender with which they identify or to which they aspire. Today's American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") employs the term Gender Dysphoria and defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

29. There are at least five distinct pathways to gender dysphoria: early childhood onset; onset near or after puberty with no prior cross gender patterns; onset after defining oneself as gay for several or more years and participating in a homosexual lifestyle; adult onset after years of heterosexual transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity. (Levine 2021.) The early childhood onset pathway and the more recently observed onset around puberty pathway are most relevant to this matter.

30. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients. (Zucker 2018 at 10.) The

developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

31. The criteria used in DSM-5 to identify Gender Dysphoria include a number of signs of discomfort with one's natal sex and vary somewhat depending on the age of the patient, but in all cases require "clinically significant distress or impairment in . . . important areas of functioning" such as social, school, or occupational settings. The symptoms must persist for at least six months.

32. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of what men and women can be. (Levine 2017 at 7.) A young child's—or even an adolescent's—understanding of this topic is quite limited. Nor can they grasp what it may mean for their future to be sterile. These children and adolescents consider themselves to be relatively unique; they do not realize that discomfort with the body and perceived social role is neither rare nor new to civilization. What is new is that such discomfort is thought to indicate that they must be a trans person.

C. Impact of gender dysphoria on minority and vulnerable groups

33. Given that, as I discuss later, a diagnosis of gender dysphoria is now frequently putting even young children on a pathway that leads to irreversible physical changes and sterilization by young adulthood, it should be of serious concern to all practitioners that minority and vulnerable groups are receiving this diagnosis at disproportionately high rates. These include: children of color (Rider et al. 2018), children with mental developmental disabilities

(Reisner et al. 2015), children on the autistic spectrum (at a rate more than 7x the general population) (Shumer et al. 2016; van der Miesen et al. 2018), children with ADHD (Becerra-Culqui et al. 2018), children residing in foster care homes, adopted children (at a rate more than 3x the general population) (Shumer et al. 2017), victims of childhood sexual or physical abuse or other "adverse childhood events" (Thoma 2021 et al.; Newcomb et al. 2020; Kozlowska et al. 2021), children with a prior history of psychiatric illness (Edwards-Leeper et al. 2017; Kaltiala-Heino et al. 2015; Littman 2018), and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys) (Rider et al. 2018 at 4).

D. Three competing conceptual models of gender dysphoria and transgender identity

34. Discussions about appropriate responses by mental health professionals ("MHPs") to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and advocates (or a single speaker at different times) view transgenderism through at least three very different paradigms, often without being aware of, or at least without acknowledging, the distinctions.

35. Gender dysphoria is **conceptualized and described by some professionals and laypersons as though it were a serious, physical medical illness that causes suffering**, comparable to diseases that are curable before it spreads, such as melanoma or sepsis. Within this paradigm, whatever is causing distress associated with gender dysphoria—whether secondary sex characteristics such as facial hair, nose and jaw shape, presence or absence of breasts, or the primary anatomical sex organs of testes, ovaries, penis, or vagina—should be removed to alleviate the illness. The promise of these interventions is the cure of the gender dysphoria.

36. Dr. Adkins appears to endorse this perspective, asserting that gender dysphoria is a "medical condition." (Adkins at 4.) It should be noted, however, that gender dysphoria is a psychiatric, not a medical, diagnosis. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and has not been specified in medical diagnostic manuals. Notably, gender dysphoria is the only psychiatric condition to be treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine 2016 at 240.)

37. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that may have been first manifested as a failure to establish a comfortable conventional sense of self in early childhood. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans lives are not exceptions to this axiom. (Levine 2016 at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address causes of the basic problem of the deeply uncomfortable self or a sense of self impaired by later adversity or abuse. The purpose is to ameliorate suffering when the underlying problem cannot be solved. MHPs first work with the patient and (ideally) family to learn about the events and processes that may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play and adolescents work out their issues by adopting various interests and identity labels.

38. There is evidence among adolescents that peer social influences through "friend groups" (Littman 2018) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity. Responsible MHPs will want to probe these potential influences

to better understand what is truly deeply tied to the psychology of the patient, and what may instead be being "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

39. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all aspects of an individual's identity evolve—often markedly—across the individual's lifetime. This includes gender. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and eternally present in an unchanging manner. As I review later, however, this assertion is not supported by science.[1]

40. The third paradigm through which gender dysphoria is alternatively conceptualized is from **a sexual minority rights perspective**. Under this paradigm, any response other than medical and societal affirmation and implementation of a patient's claim to "be" the opposite gender is a violation of the individual's civil right to self-expression. Any effort to ask "why" questions about the patient's condition, or to address underlying causes, is viewed as a violation of autonomy and civil rights. In the last few years, this paradigm has been successful in influencing public policy and the education of pediatricians, endocrinologists, and many mental health professionals. Obviously, however, this is not a medical or psychiatric perspective. Unfortunately, it appears to be the most powerful perspective that exists in the public, non-scientific debate.

E. Four competing models of therapy

41. Few would disagree that the human psyche is complex. Few would disagree that children's and adolescents' developmental pathways typically have surprising twists and turns. The complexity and unpredictability of childhood and adolescent development equally applies to

[1] Even the advocacy organization The Human Rights Campaign asserts that a person can have "a fluid or unfixed gender identity." https://www.hrc.org/resources/glossary-of-terms.

trans-identifying youth. Because of past difficulties of running placebo-controlled clinical trials in the transgender treatment arena, substantial disagreements among professionals about the causes of trans identities and their ideal treatments exist. These current disagreements might have been minimized if trans treated persons were carefully followed up to determine long term outcomes. They have not been. When we add to this to the very different current paradigms for understanding transgender phenomena, it is not scientifically surprising that disagreements are sharply drawn. It is with this in mind that I summarize below the leading approaches, and offer certain observations and opinions concerning them.

(1) The "watchful waiting" therapy model

42. In Section V.A below I review the uniform finding of eleven follow-up studies that the large majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated by social transition approaches.

43. When a pre-adolescent child presents with gender dysphoria, a "watchful waiting" approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. Watchful waiting has two versions:

a. Treating any other psychological co-morbidities—that is, other mental illnesses as defined by DSM-5 (separation anxiety disorder, attention deficit hyperactivity disorder, autism spectrum disorder, obsessive compulsive disorder, etc), or subthreshold for diagnosis but behavioral problems that the child may exhibit (school avoidance, bedwetting, inability to make friends, aggression/defiance) without a focus on gender (**model #1**); and

b. No treatment at all for anything but a regular follow-up appointment. This might be labeled a "hands off" approach **(model #2**).

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3)

44. One of the foundational principles of psychotherapy has long been to work with a patient to identify the causes of observed psychological distress and then to address those causes as a means of alleviating the distress. The National Institute of Mental Health has promulgated the idea that 75% of adult psychopathology has its origins in childhood experience.

45. Many experienced practitioners in the field of gender dysphoria, including myself, have believed that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient's life are the determinants of the patient's repudiation of his or her natal sex. (Levine 2017 at 8; Levine 2021.) I and others have reported success in alleviating distress in this way for at least some patients, whether the patient's sense of discomfort or incongruence with his or her natal sex entirely disappeared or not. Relieving accompanying psychological co-morbidities leaves the patient freer to consider the pros and cons of transition as he or she matures.

46. Among other things, the psychotherapist who is applying traditional methods of psychotherapy may help—for example—the male patient appreciate the wide range of masculine emotional and behavioral patterns as he grows older. He may discuss with his patient, for example, that one does not have to become a "woman" in order to be kind, compassionate, caring, noncompetitive, to love the arts, and to be devoted to others' feelings and needs. (Levine 2017 at 7.) Many biologically male trans individuals, from childhood to older ages, speak of their perceptions of femaleness as enabling them to discuss their feelings openly, whereas they perceive boys and men to be constrained from emotional expression within the family and larger culture, and to be aggressive. Men, of course, can be emotionally expressive, just as they can

wear pink. Converse examples can be given for girls and women. These types of ideas regularly arise during psychotherapies.

47. As I note above, many gender-nonconforming children and adolescents in recent years derive from minority and vulnerable groups who have reasons to feel isolated and have an uncomfortable sense of self. A trans identity may be a hopeful attempt to redefine the self in a manner that increases their comfort and decreases their anxiety. The clinician who uses traditional methods of psychotherapy may not focus on their gender identity, but instead work to help them to address the actual sources of their discomfort. Success in this effort may remove or reduce the desire for a redefined identity. This often involves a focus on disruptions in their attachment to parents in vulnerable children, for instance, those in the foster care system.

48. Because “watchful waiting” can include treatment of accompanying psychological co-morbidities, and the psychotherapist who hopes to relieve gender dysphoria may focus on potentially causal sources of psychological distress rather than on the gender dysphoria itself, there is no sharp line between “watchful waiting” and the psychotherapy model in the case of prepubescent children.

49. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women. On the other hand, anecdotal evidence of such outcomes does exist; I and other clinicians have witnessed reinvestment in the patient’s biological sex in some individual patients who are undergoing psychotherapy. The Internet contains many such reports, and I have published a paper on a patient who sought my therapeutic assistance to reclaim his male gender identity after 30 years living as a woman and is in fact living as a man today. (Levine 2019.) I have seen

children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist. There are now a series of articles and at least one major book on the psychological treatment of adolescents. (D'Angelo et al. 2021 at 7-16; Evans & Evans 2021.)

(3) The affirmation therapy model (model #4)

50. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with transgender identity. They argue that the child should be comprehensively re-socialized in grade school in their aspired-to gender. As I understand it, this is asserted as a reason why male students who assert a female gender identity must be permitted to compete in girls' or women's athletic events. These advocates treat any question about the causes of the child's transgender identification as inappropriate. They may not recognize the child's ambivalence. They assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition, and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

51. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. Dr. Adkins appears to follow this line, asserting that "My clinical experience . . . has been that [patients] suffer and experience worse health outcomes" when they are not permitted to enter all spaces and participate in all activities in a manner "consistent with gender identity." (Adkins at 9.) This claim is simply not supported by the clinical data we have available to us. Indeed, available long-term data contradicts Dr.

Adkins' claim. I address physical and mental health outcomes in Section VII below, and suicide in Section VIII below.

52. Dr. Adkins also asserts that fully supported social transition is the "only treatment for prepubertal children." (Adkins at 6.) As I review in the next section, this is not correct. This may be the only treatment that Dr. Adkins considers, but my own conversations and contacts lead me to believe that Dr. James Cantor was correct when he wrote that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty." (Cantor 2019 at 1.)

53. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Instead of science, this approach is currently being reinforced by an echo-chamber of approval from other like-minded child-oriented professionals who do not sufficiently consider the known negative medical and psychiatric outcomes of trans adults. Rather than recommend social transition in grade school, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with by each of them.

54. Likewise, since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

III. THERE IS NO CONSENSUS OR AGREED "STANDARD OF CARE" CONCERNING THERAPEUTIC APPROACHES TO CHILD OR ADOLESCENT GENDER DYSPHORIA.

55. Dr. Adkins states that "[t]he only treatment to avoid [ ] serious harm is to recognize the gender identity of patients with gender dysphoria and follow appropriate treatment protocols to affirm gender identity and alleviate distress," and appears to believe that transition and affirmation of children who suffer from gender dysphoria is a generally accepted "standard of care." (Adkins at 5.) It is not.

56. As I review in separate sections later, there is far too little firm clinical evidence in this field to permit any evidence-based standard of care. Given the lack of scientific evidence, it is neither surprising nor improper that—as I detailed in Section II—there is a diversity of views among practitioners as to as to the best therapeutic response for the child, adolescent, or young adult who suffers from gender dysphoria. Dr. Adkins is unwittingly confusing therapeutic precedent among those who agree with her views, armed with ideas promulgated by WPATH, with careful scientific documentation of her concepts. She presumes that her views have been scientifically established even though much has been published highlighting the lack of supportive definitive evidence.

57. Reviewing the state of opinion and practice in 2021, the Royal Australian and New Zealand College of Psychiatrists observed that "There are polarised views and mixed evidence regarding treatment options for people presenting with gender identity concerns, especially children and young people." (RANZCP, 2021.) Similarly, a few years earlier prominent Dutch researchers noted: "[T]here is currently no general consensus about the best approach to dealing with the (uncertain) future development of children with GD, and making decisions that may influence the function and/or development of the child — such as social

transition." (Ristori & Steensma 2016 at 18.)[2] In this Section, I comment on some of the more important areas of disagreement within the field.

A. Experts and organizations disagree as to whether "distress" is a necessary element for diagnoses that justifies treatment for gender identity issues.

58. As outlined in Section II.B above, "clinically significant distress" is one of the criteria used in DSM-5 to identify gender dysphoria. This indicates a heightened level of distress that rises beyond a threshold level of social awkwardness or discomfort with the changing body. It is known that many trans-identified youth with incongruence between their sexed bodies and their gender identity choose not to take hormones; their incongruence is quite tolerable as they further clarify their sexual identity elements. This population raises the questions of what distress is being measured when DSM-5 criteria are met and what else might be done about it.

59. I note that there is no "clinically significant distress" requirement in World Health Organization's International Classification of Diseases (ICD-11) criteria for gender incongruence, which rather indicates "a marked and persistent incongruence between an individual´s experienced gender and the assigned sex." (World Health Organization 2019.)

60. Therefore, even between these two committee-based authorities, there is a significant disagreement as to what constitutes a gender condition justifying life-changing interventions. To my knowledge, some American gender clinics and practitioners are essentially operating under the ICD-11 criteria rather than the APA's DSM-5 criteria, prescribing transition for children, hormonal interventions for slightly older children, and different hormones for adolescents who assert a desire for a transgender identity whether or not they are exhibiting "clinically significant distress." Others adhere to the DSM-5 diagnostic standard.

[2] *See also* Zucker 2020 which questions the merit of social transition as a first-line treatment.

61. I will add that even from within one "school of thought," such as embodied by Dr. Adkins, it is not responsible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues. There is no single pathway to the development of a trans identity and no reasonably uniform short- or long-term outcome of medically treating it. As individuals grow physically, mature psychologically, and experience or fail to experience satisfying romantic relationships, their life course depends on their differing psychological, social, familial, and life experiences. There should be no trust in assertions that trans identified youth must be treated in a particular manner to avoid harm for two reasons: first, there is no systematic data on the nature of, and the rate of harms of either affirmative treatment, no treatment, or psychological only treatment. Second, as in other youthful psychiatric and other challenges, outcomes vary.

B. Opinions and practices vary widely about the utilization of social transition for children and adolescents.

62. Dr. Adkins notes that she is a member of the World Professional Association for Transgender Health (WPATH), invokes a guidance document that that organization has chosen to publish under the title of "standards of care," and asserts that the WPATH Standards of Care are "widely accepted." (Adkins at 3, 5.) Below, I will provide some explanation of WPATH and its "Standards of Care," which are not the product of a strictly scientific organization, and are by no means accepted by all or even most practitioners as setting out best practices.

63. Here, however, I will note that WPATH does not take a position concerning whether or when social transition may be appropriate for pre-pubertal children. Instead, the WPATH "Standards of Care" states that the question of social transition for children is a "controversial issue" and calls for mental health professionals to support families in what it describes as "difficult decisions" concerning social transition.

64. Dr. Erica Anderson is a prominent practitioner in this area who identifies as a transgender woman, who was the first transgender president of USPATH, and who is a former board member of WPATH. Dr. Anderson recently resigned from those organizations and has condemned automatic approval of transition upon the request of a child or adolescent, noting that "adolescents . . . are notoriously susceptible to peer influence," that transition "doesn't cure depression, doesn't cure anxiety disorders, doesn't cure autism-spectrum disorder, doesn't cure ADHD," and instead that "a comprehensive biopsychosocial evaluation" should proceed allowing a child to transition. (Davis 2022.) And as I have explained previously, my own view based on 50 years of experience in this area favors strong caution before approving life-altering interventions such as social transition, puberty blockers, or cross-sex hormones.

C. The WPATH "Standards of Care" is not an impartial or evidence-based document.

65. Because WPATH is frequently cited by advocates of social, hormonal, and surgical transition, I provide some context concerning that private organization and its "Standards of Care."

66. I was a member of the Harry Benjamin International Gender Dysphoria Association from 1974 until 2001. From 1997 through 1998, I served as the Chairman of the eight-person International Standards of Care Committee that issued the fifth version of the Standards of Care. I resigned my membership in 2002 due to my regretful conclusion that the organization and its recommendations had become dominated by politics and ideology, rather than by scientific process, as it was years earlier. In approximately 2007, the Harry Benjamin International Gender Dysphoria Association changed its name to the World Professional Association for Transgender Health.

67. WPATH is a voluntary membership organization. Since at least 2002, attendance at its biennial meetings has been open to trans individuals who are not licensed professionals. While this ensures taking patients' needs into consideration, it limits the ability for honest and scientific debate, and means that WPATH can no longer be considered a purely professional organization.

68. WPATH takes a decided view on issues as to which there is a wide range of opinion among professionals. WPATH explicitly views itself as not merely a scientific organization, but also as an advocacy organization. (Levine 2016 at 240.) WPATH is supportive to those who want sex reassignment surgery ("SRS"). Skepticism as to the benefits of SRS to patients, and strong alternate views, are not well tolerated in discussions within the organization or their educational outreach programs. Such views have been known to be shouted down and effectively silenced by the large numbers of nonprofessional adults who attend the organization's biennial meetings. Two groups of individuals that I regularly work with have attended recent and separate WPATH continuing education sessions. There, questions about alternative approaches were quickly dismissed with "There are none. This is how it is done." Such a response does not accurately reflect what is known, what is unknown, and the diversity of clinical approaches in this complex field.

69. The Standards of Care ("SOC") document is the product of an effort to be balanced, but it is not politically neutral. WPATH aspires to be both a scientific organization and an advocacy group for the transgendered. These aspirations sometimes conflict. The limitations of the Standards of Care, however, are not primarily political. They are caused by the lack of rigorous research in the field, which allows room for passionate convictions on how to care for the transgendered. And, of course, once individuals have socially, medically, and surgically

transitioned, WPATH members and the trans people themselves at the meetings are committed to supporting others in their transitions. Not only have some trans participants been distrustful or hostile to those who question the wisdom of these interventions, their presence makes it difficult for professionals to raise their concerns. Vocal trans rights advocates have a worrisome track record of attacking those who have alternative views. (Dreger 2015.)

70. In recent years, WPATH has fully adopted some mix of the medical and civil rights paradigms. It has downgraded the role of counseling or psychotherapy as a requirement for these life-changing processes. WPATH no longer considers preoperative psychotherapy to be a requirement. It is important to WPATH that the person has gender dysphoria; the pathway to the development of this state is not. (Levine 2016 at 240.) The trans person is assumed to have thoughtfully considered his or her options before seeking hormones, for instance.

71. Most psychiatrists and psychologists who treat patients suffering sufficiently severe distress from gender dysphoria to seek inpatient psychiatric care are not members of WPATH. Many psychiatrists, psychologists, and pediatricians who treat some patients suffering gender dysphoria on an outpatient basis are not members of WPATH. WPATH represents a self-selected subset of the profession along with its many non-professional members; it does not capture the clinical experiences of others. WPATH claims to speak for the medical profession; however, it does not welcome skepticism and therefore, deviates from the philosophical core of medical science. There are pediatricians, psychiatrists, endocrinologists, and surgeons who object strongly, on professional grounds, to transitioning children and providing affirmation in a transgender identity as the first treatment option. WPATH does not speak for all of the medical profession.

72. In 2010 the WPATH Board of Directors issued a statement advocating that incongruence between sex and felt gender identity should cease to be identified in the DSM as a pathology.[3] This position was debated but not adopted by the (much larger) American Psychiatric Association, which maintained the definitions and diagnoses of gender dysphoria as a pathology in the DSM-5 manual issued in 2013.

73. In my experience some current members of WPATH have little ongoing experience with the mentally ill, and many trans care facilities are staffed by MHPs who are not deeply experienced with recognizing and treating frequently associated psychiatric co-morbidities. Further, being a mental health professional, per se, does not guarantee experience and skill in recognizing and effectively intervening in serious or subtle patterns. Because the 7th version of the WPATH SOC deleted the requirement for therapy, trans care facilities that consider these Standards sufficient are permitting patients to be counseled to transition by means of social presentation, hormones, and surgery by individuals with masters rather than medical degrees.

D. Opinions and practices differ widely with respect to the proper role of psychological counseling before, as part of, or after a diagnosis of gender dysphoria.

74. In Version 7 of its Standards of Care, released in 2012, WPATH downgraded the role of counseling or psychotherapy, and the organization no longer sees psychotherapy without transition and hormonal interventions as a potential path to eliminate gender dysphoria by enabling a patient to return to or achieve comfort with the gender identity aligned with his or her biology.

[3] WPATH *De-Psychopathologisation Statement* (May 26, 2010), available at wpath.org/policies (last accessed January 21, 2020).

75. Around the world, many prominent voices and practitioners disagree. For example, renowned gender therapists Dr. Laura Edwards-Leeper and Dr. Erica Anderson (who, as mentioned above, identifies as a transgender woman) have recently spoken out arguing that children and adolescents are being subjected to puberty blockers and hormonal intervention far too quickly, when careful and extended psychotherapy and investigation for potential causes of feelings of dysphoria (such as prior sexual abuse) should be the first port of call and might resolve the dysphoria. (Edwards-Leeper & Anderson 2021; Davis 2022.)

76. In a recently published position statement on gender dysphoria, the Royal Australian and New Zealand College of Psychiatrists emphasized the critical nature of mental health treatment for gender dysphoric minors, stressing "the importance of the psychiatrist's role to undertake thorough assessment and evidence-based treatment ideally as part of a multidisciplinary team, especially highlighting co-existing issues which may need addressing and treating." The Royal College also emphasized the importance of assessing the "psychological state and context in which Gender Dysphoria has arisen," before any treatment decisions are made. (RANZCP, 2021.)

77. Dr. Paul Hruz of the University of Washington St. Louis Medical School has noted, "The WPATH has rejected psychological counseling as a viable means to address sex–gender discordance with the claim that this approach has been proven to be unsuccessful and is harmful (Coleman et al. 2012). Yet the evidence cited to support this assertion, mostly from case reports published over forty years ago, includes data showing patients who benefited from this approach (Cohen-Kettenis and Kuiper 1984)." (Hruz 2020.)

E. Opinions and practices vary widely with respect to the administration of puberty blockers and cross-sex hormones.

78. There is likewise no broadly accepted standard of care with respect to use of puberty blockers. The WPATH Standards of Care explicitly recognize the lack of any consensus on this important point, stating: "Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. . . The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings."

79. The use of puberty blockers as a therapeutic intervention for gender dysphoria is often justified by reference to the seminal work of a respected Dutch research team that developed a protocol that administered puberty blockers to children no younger than age 14. However, it is well known that many clinics in North America now administer puberty blockers to children at much younger ages than the "Dutch Protocol" allows. (Zucker 2019.) The Dutch protocol only treated children with these characteristics: a stable cross gender identity from early childhood; dysphoria that worsened with the onset of puberty; were otherwise psychologically healthy; had healthy families; the patient and family agreed to individual and family counselling throughout the protocol. But the experience and results of the Dutch model is being used as a justification for giving puberty blockers to children who differ considerably from these criteria. Its authors have also recently noted this fact. (de Vries 2020.)

80. However, Zucker notes that "it is well known" that clinicians are administering cross-sex hormones, and approving surgery, at ages lower than the minimum age thresholds set by that "Dutch Protocol." (Zucker 2019 at 5.)

81. Similarly, at least one prominent clinic—that of Dr. Safer at Columbia's Mt. Sinai Medical Center—is quite openly admitting patients for even *surgical* transition who are not eligible under the criteria set out in WPATH's Standards of Care. A recent study published by Dr. Safer and colleagues revealed that of a sample of 139 individuals, 45% were eligible for surgery "immediately" under the center's own criteria, while only 15% were eligible under WPATH's criteria. That is, *three times* as many patients immediately qualified for surgery under the center's loose standards than would have qualified under WPATH criteria. (Lichenstein et al. 2020.)

82. Internationally, there has been a recent marked trend *against* use of puberty blockers, as a result of extensive evidence reviews by national medical bodies, which I discuss later. The main gender clinic in Sweden has declared that it will no longer authorize use of puberty blockers for minors below the age of 16. Finland has similarly reversed its course, issuing new guidelines that allow puberty blockers only on a case-by-case basis after an extensive psychiatric assessment. A landmark legal challenge against the UK's National Health Service in 2020 by "detransitioner" Keira Bell led to the suspension of the use of puberty blockers and new procedures to ensure better psychological care, as well as prompting a thorough evidence review by the National Institute for Health and Care Excellence (NICE 2021a; NICE 2021b).[4]

83. In this country, some voices in the field are now publicly arguing that *no* comprehensive mental health assessment at all should be required before putting teens on puberty blockers or cross-sex hormones (Ghorayshi 2022), while Dr. Anderson and Dr.

[4] The decision requiring court approval for administration of hormones to any person younger than age 16 was later reversed on procedural grounds by the Court of Appeal and is currently under consideration by the UK Supreme Court.

Edwards-Leeper argue that U.S. practitioners are already moving too quickly to hormonal interventions. (Edwards-Leeper & Anderson 2021; Davis 2022.) It is evident that opinions and practices are all over the map.

84. It is true that a committee of the American Academy of Pediatricians has issued a statement supporting administration of puberty blockers to children diagnosed with gender dysphoria. It is also true that no other American medical association has endorsed the use of puberty blockers, and that pediatricians are neither endocrinologists nor psychiatrists. Dr. James Cantor published a peer-reviewed paper detailing that the Academy's statement is not evidence-based and misdescribed the few scientific sources it did reference. (Cantor 2019.) It has been well noted in the field that the AAP has declined invitations to publish any rebuttal to Dr. Cantor's analysis. But this is all part of ongoing debate, simply highlighting the absence of any generally agreed standard of care.

85. Dr. Adkins asserts that the Society's 2017 Practice Guidelines on Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (Hembree et al. 2017) amount to "widely accepted standards of care" that were "developed through rigorous scientific processes." (Adkins at 2, 5 and 6.)

86. Contrary to Dr. Adkins' assertion, the 2017 Endocrine Society Guidelines themselves expressly state that they are *not* "standards of care." The document states: "The guidelines cannot guarantee any specific outcome, *nor do they establish a standard of care*. The guidelines are not intended to dictate the treatment of a particular patient." (Hembree et al. 2017 at 3895 (emphasis added).) Nor do the Guidelines claim to be the result of a "rigorous scientific process." Rather, they expressly advise that their recommendations concerning use of puberty blockers are based only on "low quality" evidence.

87. Dr. Adkins notes that the 2017 Guidelines assert that: "patients with gender dysphoria often must be treated with 'a safe and effective hormone regimen. . .'" (Adkins at 6.) Notably, however, the Guidelines do not make any firm statement that use of puberty blockers for this purpose *is* safe, and the Guidelines go no further than "suggest[ing]" use of puberty blockers—language the Guidelines warn represents only a "weak recommendation." (Hembree 2017 at 3872.) Several authors have pointed out that not only were the Endocrine Society suggestions regarding use of puberty blockers reached on the basis of "low quality" evidence, but its not-quite claims of 'safety' and 'efficacy' are starkly contradicted by several in-depth evidence reviews. (Laidlaw et al., 2019; Malone et al. 2021.) I detail these contradictory findings in more detail in Section VII below.

88. While there is too little meaningful clinical data and no consensus concerning best practices or a "standard of care" this area, there are long-standing ethical principles that do or should bind all medical and mental health professionals as they work with, counsel, and prescribe for these individuals.

89. One of the oldest and most fundamental principles guiding medical and psychological care—part of the Hippocratic Oath—is that the physician must "do no harm." This states an ethical responsibility that cannot be delegated to the patient. Physicians themselves must weigh the risks of treatment against the harm of not treating. If the risks of treatment outweigh the benefits, principles of medical ethics prohibit the treatment.

IV. TRANSGENDER IDENTITY IS NOT BIOLOGICALLY BASED.

90. Dr. Safer asserts that "Although the detailed mechanisms are unknown, there is a medical consensus that there is a significant biologic component underlying gender identity" and

that gender identity is a "largely biological phenomenon." (Safer at 5, 6.) Many advocates of affirmative care assert this belief.

91. However, it is not true. There is no medical consensus that transgender identity has any biological basis. Furthermore, there is considerable well-documented evidence that is inconsistent with the hypothesis of a biological basis for gender identity—at least in the large majority of currently-presenting patients.

A. No theory of biological basis has been scientifically validated.

92. At the outset, the attempt to identify a single "typically . . . biological" cause for psychiatric conditions (including gender dysphoria) has been strongly criticized as "out of step with the rest of medicine" and as a lingering "ghost" of an understanding of the nature of psychiatric conditions that is now broadly disproven. (Kendler 2019 at 1088-1089.) Gender dysphoria is defined and diagnosed only as a psychiatric, not a medical, condition.

93. Nonetheless, in a published article, Dr. Safer has referred to data that he asserts supports the existence of "a fixed, biologic basis for gender identity." (Saraswat et al. 2015 at 199.) But on the contrary, this article itself states that studies attempting to find an association between genetics and transgender identification "have been contradictory," and that "no statistically significant association between particular genes [and transgender identity] has been described." (Saraswat 2015 at 202.)

94. Similarly, while some have pointed to very small brain scan studies as evidence of a biological basis, no studies of brain structure of individuals identifying as transgender have found any statistically significant correlation between any distinct structure or pattern and transgender identification, after controlling for sexual orientation and exposure to exogenous hormones. (Sarawat et al. 2015 at 202; Frigerio et al. 2021.)

95. Indeed, the Endocrine Society 2017 Guidelines recognizes: "With current knowledge, we cannot predict the psychosexual outcome for any specific child" and "there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty." (Hembree et al. 2017 at 3876.)

96. In short, no biological test or measurement has been identified that provides any ability to predict which children will exhibit, and which children will persist in, gender dysphoria or a transgender identification. Unless and until such a test is identified, the theory of a biological basis is a hypothesis still searching for support. A hypothesis is not a fact, and responsible scientists will not confuse hypothesis with fact.

B. Large changes across time and geography in the epidemiology of transgender identification are inconsistent with the hypothesis of a biological basis for transgender identity.

97. In fact, there is substantial evidence that the "biological basis" theory is incorrect, at least with respect to the large majority of patients presenting with gender dysphoria today.

98. **Vast changes in incidence:** Historically, there were very low reported rates of gender dysphoria or transgender identification. In 2013, the DSM-5 estimated the incidence of gender dysphoria in adults to be at 2-14 per 100,000, or between 0.002% and 0.014%. (APA 2013 at 454.) Recently however, these numbers have increased dramatically, particularly in adolescent populations. Recent surveys estimate that between 2-9% of high school students self-identify as transgender or "gender non-conforming." with a significantly large increase in adolescents claiming "nonbinary" gender identity as well. (Johns et al. 2019; Kidd et al. 2021.) Consistent with these surveys, gender clinics around the world have seen numbers of referrals increase rapidly in the last decade, with the Tavistock clinic in London seeing a 30-fold increase in the last decade (GIDS 2019), and similar increases being observed in Finland (Kaltiala-Heino

et al. 2018), the Netherlands (de Vries 2020), and Canada (Zucker 2019). The rapid change in the number of individuals experiencing gender dysphoria points to social and cultural, not biological, causes.

99. **Large change in sex ratio:** In recent years there has been a marked shift in the sex ratio of patients presenting with gender dysphoria or transgender identification. The Tavistock clinic in London saw a ratio of 4 biological females(F):5 biological males(M) shift to essentially 11F:4M in a decade. (GIDS 2019.) One researcher summarizing multiple sources documented a swing of 1F:2M or 1F:1.4M through 2005 to 2F:1M generally (but as high as 7F:1M) in more recent samples. (Zucker 2019 at 2.) This phenomenon has been noted by Dr. Erica Anderson, who said: "The data are very clear that adolescent girls are coming to gender clinics in greater proportion than adolescent boys. And this is a change in the last couple of years. And it's an open question: What do we make of that? We don't really know what's going on. And we should be concerned about it." (Davis 2022.) Again, this large and rapid change in who is experiencing gender dysphoria points to social, not biological, causes.

100. **Clustering**: Dr. Littman's recent study documented "clustering" of new presentations of gender dysphoria among natal females in specific schools and among specific friend groups. This again points strongly to social causes for gender dysphoria at least among the adolescent female population. (Littman 2018.)

101. **Desistance:** As I discuss later, there are very high levels of desistance among children diagnosed with gender dysphoria, as well as increasing (or at least increasingly vocal) numbers of individuals who first asserted a transgender identity during or after adolescence, underwent substantial medical interventions to "affirm" that trans-identity, and then "desisted"

and reverted to a gender identity congruent with their sex. (See Section V.B below.) These narratives, too, point to a social and/or psychological cause, rather than a biological one.

102. **"Fluid" gender identification:** Advocates and some practitioners assert that gender identity is not binary, but can span an almost endless range of gender identity self-labels, which a given individual may try on, inhabit, and often discard. (A recent article identifies 72.[5]) I have not heard any theory offered for how there is or could be a biological basis for gender identity as now expansively defined.

103. I frequently read attempts to explain away the points in this Section IV. They include: these problems always existed, but children are now learning that there are effective treatments for their dilemma and are simply seeking them. And; children have hidden their trans identity throughout childhood and now that trans people are recognized and accepted, they are presenting themselves. And; now pediatricians realize that girls can have gender dysphoria and are referring them to gender clinics. But these are all mere hypotheses unsupported by concrete evidence. One set of unproven hypotheses cannot provide support for the unproven hypothesis of biological basis. And none of these hypotheses could even potentially explain the failure of science thus far to identify any predictive biological marker of transgender identification.

104. **Therapies affect gender identity outcomes:** Finally, the evidence shows that therapeutic choices can have a powerful effect on whether and how gender identity does change, or gender dysphoria desists. Social transition of juveniles, for instance, strongly influences gender identity outcomes to such an extent that it has been described a "unique predictor of

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[5] Allarakha, *What Are the 72 Other Genders?*, MedicineNet, available at: https://www.medicinenet.com/what_are_the_72_other_genders/article.htm

persistence." (See Section V.B below.) Again, this observation cuts against the hypothesis of biological origin.

C. Disorders of sexual development (or DSDs) and gender identity are very different phenomena, and it is an error to conflate the two.

105. Dr. Adkins spends much of her report discussing individuals who suffer from disorders of sexual development (DSDs), apparently as evidence that sex is not binary or clearly defined, or as somehow supporting the idea that transgender identification has a biological basis. (Adkins at 9.) I have extensively detailed that sex is clear, binary, and determined at conception. (Section II.) Here I explain that gender dysphoria is an entirely different phenomenon than DSDs—which unlike transgender identity are indeed biological phenomena. It is an error to conflate the two distinct concepts.

106. Every DSD reflects a genetic enzymatic defect with negative anatomic and physiological consequences. As the Endocrine Society recognized in a 2021 statement: "Given the complexities of the biology of sexual determination and differentiation, it is not surprising that there are dozens of examples of variations or errors in these pathways associated with genetic mutations that are now well known to endocrinologists and geneticists; in medicine, these situations are generally termed *disorders of sexual development* (DSD) or *differences in sexual development*." Gender Identity on the other hand is uniformly defined as a subjective "sense" of being, a feeling or state of mind. (Section II.C.)

107. The vast majority of those who experience gender dysphoria or a transgender identity do not suffer from any DSD, nor from any genetic enzymatic disorder at all. Conversely, many who suffer from a DSD do not experience a gender identity different from their chromosomal sex (although some may). In short, those who suffer from gender dysphoria are not a subset of those who suffer from a DSD, nor are those who suffer from a DSD a subset of those

who suffer from gender dysphoria. The two are simply different phenomena, one physical, the other mental, defined only as a psychiatric condition. The issue here is not whether biological forces play a role in personality development; it is whether there is strong evidence that it is determinative. Science has come too far to revert to single explanations for gender dysphoria or any psychiatric diagnosis.

108. The importance of this distinction is evident from the scientific literature. For example, in a recent study of clinical outcomes for gender dysphoric patients, Tavistock Clinic researchers *excluded* from their analysis any patients who did not have "normal endocrine function and karyotype consistent with birth registered sex." (Carmichael et al. 2021 at 4.) In other words, the researchers specifically *excluded* from their study anyone who suffered from genetic-based DSD, or a DSD comprising any serious defect in hormonal use pathways, in order to ensure the study was focused only on individuals experiencing the psychological effects of what we might call "ordinary" gender dysphoria.

D. Studies of individuals born with DSDs suggest that there may be a biological predisposition towards *typical* gender identifications, but provide no support for a biological basis for *trans*gender identification.

109. Studies of individuals born with serious DSDs have been pointed to as evidence of a biological basis for transgender identification. They provide no such support.

110. One well-known study by Meyer-Bahlburg reviewed the case histories of a number of XY (i.e. biologically male) individuals born with severe DSDs who were surgically "feminized" in infancy and raised as girls. (Meyer-Bahlburg 2005.) The majority of these individuals nevertheless later adopted male gender identity—suggesting a strong biological predisposition towards identification aligned with genetic sex, even in the face of feminized genitalia from earliest childhood, and parental "affirmation" in a transgender identity. But at the same time, the fact that some of these genetically male individuals did *not* later adopt male

gender identity serves as evidence that medical and social influences can indeed encourage and sustain transgender identification.

111. Importantly, the Meyer-Bahlburg study did *not* include any individuals who were assigned a gender identity congruent with their genetic sex who subsequently adopted a *trans*gender identity. Therefore, the study can provide no evidence of any kind that supports the hypothesis of a biological basis for *trans*gender identity. A second study in this area (Reiner & Gearhart 2004) likewise considered exclusively XY subjects, and similarly provides evidence only for a biological bias towards a gender identity congruent with one's genetic sex, even in the face of medical and social "transition" interventions. None of this provides any evidence at all of a biological basis for transgender identity.

V. GENDER IDENTITY IS EMPIRICALLY NOT FIXED FOR MANY INDIVIDUALS.

112. Dr. Safer states that gender identity is "durable and cannot be changed by medical intervention." (Safer at 5.) Dr. Adkins likewise states that gender identity "cannot be voluntarily changed." (Adkins at 4.) There is extensive evidence that this is not correct. Instead, gender identity changes over time for many individuals.[6] I summarize their two opinions as: they assert that a trans identity in a child or adolescent is immutable—unchangeable by medical, psychotherapeutic, or developmental processes.

A. Most children who experience gender dysphoria ultimately "desist" and resolve to cisgender identification.

113. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large

[6] See n1 *supra*.

majority of patients, absent a substantial intervention such as social transition or puberty blocking hormone therapy, it does *not* persist through puberty.

114. A recent article reviewed all existing follow-up studies that the author could identify of children diagnosed with gender dysphoria (11 studies), and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor 2019 at 1.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance." (Adelson et al. 2012 at 963; see also Cohen-Kettinis 2008 at 1895.) The Endocrine Society recognized this important baseline fact in its 2017 Guidelines. (Hembree 2017 at 3879.) It should be noted that the reason that the Dutch Protocol waited until age 14 to initiate puberty blockers was that it was well known that many children would desist if left free of hormonal intervention until that age.

115. Findings of high levels of desistance among children who experience gender dysphoria or incongruence have been reaffirmed in the face of critiques through thorough reanalysis of the underlying data. (Zucker 2018.)

116. As I explained in detail in Section IV above, it is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist.

117. It does appear that prevailing circumstances during particularly formative years can have a significant impact on the outcome of a juvenile's gender dysphoria. A 2016 study reviewing the follow-up literature noted that "the period between 10 and 13 years" was "crucial" in that "both persisters and desisters stated that the changes in their social environment, the

anticipated and actual feminization or masculinization of their bodies, and the first experiences of falling in love and sexual attraction in this period, contributed to an increase (in the persisters) or decrease (in the desisters) of their gender related interests, behaviors, and feelings of gender discomfort." (Ristori & Steensma 2016 at 16.) As I discuss in Section VI below, there is considerable evidence that early transition and affirmation causes far more children to persist in a transgender identity.

B. Desistance is increasingly observed among teens and young adults who first manifest GD during or after adolescence.

118. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." I have observed an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some point during their teen years, and young "detransitioners" (individuals in the process of reidentifying with their birth sex after having undergone a gender transition) are now receiving increasing attention in both clinical literature and social media channels. (It is my understanding that March 12, 2022, is scheduled to be Detransition Awareness Day.)

119. Almost all scientific articles on this topic have appeared within the last few years. Perhaps this historic lack of coverage is not entirely surprising – one academic who undertook an extensive review of the available scientific literature in 2021 noted that the phenomenon was "socially controversial" in that it "poses significant professional and bioethical challenges for those clinicians working in the field of gender dysphoria." (Expósito Campos 2021 at 270.) This review reported on multifarious reasons for why individuals were motivated to detransition, which included coming to "understand[ ] how past trauma, internalized sexism, and other psychological difficulties influenced the experience of GD."

120. In 2021, Lisa Littman of Brown University conducted a ground-breaking study of 100 teenage and young adults who had transitioned and lived in a transgender identity for a number of years, and then "detransitioned" or changed back to a gender identity matching their sex. Littman noted that the "visibility of individuals who have detransitioned is new and may be rapidly growing." (Littman 2021 at 1.) Of the 100 detransitioners included in Littman's study, 60% reported that their decision to detransition was motivated (at least in part) by the fact that they had become more comfortable identifying as their natal sex, and 38% had concluded that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition. (Littman 2021 at 9.)

121. A significant majority (76%) did not inform their clinicians of their detransition. (Littman 2021 at 11.)

122. A similar study that recruited a sample of 237 detransitioners (the large majority of whom had initially transitioned in their teens or early twenties) similarly reported that a common reason for detransitioning was the subject's conclusion that his or her gender dysphoria was related to other issues (70% of the sample). (Vandenbussche 2021.)

123. The existence of increasing numbers of youth or young adult detransitioners has also been recently noted by Dr. Edwards-Leeper and Dr. Anderson. (Edwards-Leeper & Anderson 2021.) Edwards-Leeper and Anderson noted "the rising number of detransitioners that clinicians report seeing (they are forming support groups online)" which are "typically youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it." Other clinicians working with detransitioners have also noted the recent phenomenon. (Marchiano 2020.)

124. A growing body of evidence suggests that for many teens and young adults, a post-pubertal onset of transgender identification can be a transient phase of identity exploration, rather than a permanent identity, as evidenced by a growing number of young detransitioners (Entwistle 2020; Littman 2021; Vandenbussche 2021). Previously, the rate of detransition and regret was reported to be very low, although these estimates suffered from significant limitations and were likely undercounting true regret (D'Angelo 2018). As gender-affirmative care has become popularized, the rate of detransition appears to be accelerating.

125. A recent study from a UK adult gender clinic observed that 6.9% of those treated with gender-affirmative interventions detransitioned within 16 months, and another 3.4% had a pattern of care suggestive of detransition, yielding a rate of probable detransition in excess of 10%. Another 21.7%, however, disengaged from the clinic without completing their treatment plan. While some of these individuals later re-engaged with the gender service, the authors concluded, "detransitioning might be more frequent than previously reported." (Hall et al. 2021).

126. Another study from a UK primary care practice found that 12.2% of those who had started hormonal treatments either detransitioned or documented regret, while the total of 20% stopped the treatments for a wider range of reasons. The mean age of their presentation with gender dysphoria was 20, and the patients had been taking gender-affirming hormones for an average 5 years (17 months-10 years) prior to discontinuing. Comparing these much higher rates of treatment discontinuation and detransition to the significantly lower rates reported by the older studies, the researchers noted: "Thus, the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields" (Boyd et al. 2022 at 15.) Indeed, given that regret may take up to 8-11 years to materialize (Dhejne et al., 2014; Wiepjes et al., 2018), many more

detransitioners are likely to emerge in the coming years. Detransitioner research is still in its infancy, but the Littman and Vandenbussche studies in 2021 both report that detransitioners from the recently transitioning cohorts feel they were rushed into medical gender-affirmative interventions with irreversible effects, often without the benefit of appropriate, or in some instances any, psychologic exploration.

VI. TRANSITION AND AFFIRMATION IS AN IMPORTANT PSYCHOLOGICAL AND MEDICAL INTERVENTION THAT CHANGES GENDER IDENTITY OUTCOMES.

A. If both a typical gender or a transgender long-term gender identity outcome are possible for a particular patient, the alternatives are not medically neutral.

127. Where a juvenile experiences gender dysphoria, the gender identity that is stabilized will have a significant impact on the course of their life. Living in a transgender identity for a time will make desistance, if it is ever considered, more difficult to accomplish.

128. If the juvenile desists from the gender dysphoria and becomes reasonably comfortable with a gender identity congruent with their sex—the most likely outcome from a statistical perspective absent affirming intervention—the child will not require ongoing pharmaceutical maintenance and will not have their fertility destroyed post-puberty.

129. However, if the juvenile persists in a transgender identity, under current practices, the child is most likely to require regular administration of hormones for the rest of their lives, exposing them to significant physical, mental health, and relational risks (which I detail in Section IX below), as well as being irreversibly sterilized chemically and/or surgically. The child is therefore rendered a “patient for life” with complex medical implications further to a scientifically unproven course of treatment.

B. Social transition of young children is a powerful psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance.

130. Dr. Adkins asserts that social transition is a "a critical part" of the treatment of gender dysphoria. (Adkins at 6, 7). Rather, social transition has a critical *effect* on the persistence of gender dysphoria. It is evident from the scientific literature that engaging in therapy that encourages social transition before or during puberty—which would include participation on athletic teams designated for the opposite sex—is a psychotherapeutic intervention that dramatically changes outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood." (Guss et al. 2015 at 421.) Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their natal sex—instead persist in a transgender identity. (Zucker 2018 at 7.)

131. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker 2018 at 7[7]; Steensma et al. 2013.)[8] Another researcher observed that a partial or complete gender

[7] Zucker found social transition by the child to be strongly correlated with persistence for natal boys, but not for girls. (Zucker 2018 at 5.)

[8] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or

social transition prior to puberty "proved to be a unique predictor of persistence." (Singh et al. 2021 at 14.)

132. Some vocal practitioners of prompt affirmation and social transition even proudly claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex.[9] This is a very large change as compared to the desistance rates documented apart from social transition.

133. Even voices generally supportive of prompt affirmation and social transition are acknowledging a causal connection between social transition and this change in outcomes. As the Endocrine Society recognized in its 2017 Guidelines: "If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty. . . [S]ocial transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence." (Hembree et al. 2017 at 3879.) The fact is that these unproven interventions with the lives of kids and their families have systematically documented outcomes. Given this observed phenomenon, I agree with Dr. Ken Zucker who has written that social transition in children must be considered "a form of psychosocial treatment." (Zucker 2020 at 1.)

134. Moreover, as I review below, social transition cannot be considered or decided alone. Studies show that engaging in social transition starts a juvenile on a "conveyor belt" path

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partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma 2013 at 584.

[9] *See, e.g.,* Ehrensaft 2015 at 34: "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."

that almost inevitably leads to the administration of puberty blockers, which in turn almost inevitably leads to the administration of cross-sex hormones. The emergence of this well-documented path means that the implications of taking puberty blockers *and* cross-sex hormones must be taken into account even where "only" social transition is being considered or requested by the child or family. As a result, there are a number of important "known risks" associated with social transition.

C. Administration of puberty blockers is a powerful medical and psychotherapeutic intervention that radically changes outcomes, almost eliminating desistance on the historically observed timeline.

135. Dr. Adkins speaks of the use of puberty blockers as though this major hormonal disruption of some of the most basic aspects of ordinary human development were entirely benign, acting as a "pause." (Adkins at 7.) This optimistic view is not based on science. In fact, it should be understood that puberty blockers are usually administered to early-stage adolescents as part of a path that includes social transition. Moreover, medicine does not know what the long-term health effects on bone, brain, and other organs are of a "pause" between ages 11-16. Medicine also does not know if the long-term effects of these compounds are different in boys than in girls. The mental health professional establishment likewise does not know the long-term effects on coping skills, interpersonal comfort, and intimate relationships of this "pause" while one's peers are undergoing their maturational gains in these vital arenas of future mental health. I address medical, social, and mental health risks associated with the use of puberty blockers in Section IX. Here, I note that the data strongly suggests that the administration of puberty blockers, too, must be considered to be a component of a "psychosocial treatment" with complex implications, rather than a "pause."

136. Multiple studies show that the large majority of children who begin puberty blockers go on to receive cross-sex hormones. (de Vries 2020 at 2.) A recent study by the

Tavistock and Portman NHS Gender Identity Development Service (UK)—the world's largest gender clinic—found that 98% of adolescents who underwent puberty suppression continued on to cross-sex hormones. (Carmichael et al 2021 at 12.)[10]

137. These studies demonstrate that going on puberty blockers virtually eliminates the possibility of desistance in juveniles. Rather than a "pause," puberty blockers appear to act as a psychosocial "switch," decisively shifting many children to a persistent transgender identity. Therefore, as a practical and ethical matter the decision to put a child on puberty blockers must be considered as the equivalent of a decision to put that child on cross-sex hormones, with all the considerations and informed consent obligations implicit in that decision.

VII. TRANSITION AND AFFIRMATION ARE EXPERIMENTAL THERAPIES THAT HAVE NOT BEEN SHOWN TO IMPROVE MENTAL OR PHYSICAL HEALTH OUTCOMES BY YOUNG ADULTHOOD.

138. It is undisputed that children and adolescents who present with gender dysphoria exhibit a very high level of mental health comorbidities. (Section II.C.) Whether the gender dysphoria is cause or effect of other diagnosed or undiagnosed mental health conditions, or whether these are merely coincident comorbidities, is hotly disputed, but the basic fact is not.

139. Dr. Adkins asserts that when the "transition, affirmation, and hormones" therapy that she advocates is followed, "gender dysphoria is easily managed" (Adkins at 5), implying that transition and hormone therapy have been proven to be effective in relieving gender dysphoria and the general mental health distress that broadly afflicts these children and adolescents. This is scientifically incorrect. It ignores both what is known and what is unknown.

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[10] *See also* Brik 2020 where Dutch researchers found nearly 97% of adolescents who received puberty blockers proceeded to cross-sex hormones.

A. The knowledge base concerning therapies for gender dysphoria is "very low quality."

140. At the outset, it is important for all sides to admit that the knowledge base concerning the causes and treatment of gender dysphoria has low scientific quality.

141. In evaluating claims of scientific or medical knowledge, it is axiomatic in science that no knowledge is absolute, and to recognize the widely accepted hierarchy of reliability when it comes to "knowledge" about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such "knowledge" may be based upon data comprising:

a. Expert opinion—it is perhaps surprising to educated laypersons that expert opinion standing alone is the lowest form of knowledge, the least likely to be proven correct in the future, and therefore does not garner as much respect from professionals as what follows;

b. A single case or series of cases (what could be called anecdotal evidence) (Levine 2016 at 239.);

c. A series of cases with a control group;

d. A cohort study;

e. A randomized double-blind clinical trial;

f. A review of multiple trials;

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

142. Prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has

recognized that "Different clinical approaches have been advocated for childhood gender discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against … possible deleterious effects." (Adelson et al. at 968–69.) Similarly, the American Psychological Association has stated, "because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children." (APA 2015 at 842.)

143. Critically, "there are no randomized control trials with regard to treatment of children with gender dysphoria." (Zucker 2018 at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect of alternative treatments, the knowledge base remains primarily at the level of the practitioner's exposure to individual cases, or multiple individual cases. As a result, claims to certainty are not justifiable. (Levine 2016 at 239.)

144. Within the last two years, at least three formal evidence reviews concerning hormonal interventions for gender dysphoria have been conducted. All three found all of the available clinical evidence to be very low quality.

145. The British National Health Service (NHS) commissioned formal "evidence reviews" of all clinical papers concerning the efficacy and safety of puberty blockers and cross-sex hormones as treatments for gender dysphoria. These evidence reviews were performed by the U.K. National Institute for Health and Care Excellence (NICE), applying the respected "GRADE" criteria for evaluating the strength of clinical evidence.

146. Both the review of evidence concerning puberty blockers and the review of evidence concerning cross-sex hormones were published in 2020, and both found that *all* available evidence as to both efficacy and safety was "very low quality" according to the

GRADE criteria. (NICE 2021a; NICE 2021b.) “Very low quality” according to GRADE means there is a high likelihood that the patient *will not experience* the hypothesized benefits of the treatment. (Balshem et al. 2011.)

147. Similarly, the highly respected Cochrane Library—the leading source of independent systematic evidence reviews in health care—commissioned an evidence review concerning the efficacy and safety of hormonal treatments now commonly administered to “transitioning transgender women” (i.e., testosterone suppression and estrogen administration to biological males). That review, also published in 2020, concluded that “We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition.” (Haupt et al. 2020 at 2.) It must be understood that both the NICE and the Cochrane reviews considered *all* published scientific studies concerning these treatments.

148. As to social transition, as I have noted above, considerable evidence suggests that socially transitioning a pre-pubertal child puts him or her on a path from which very few children escape—a path which includes puberty blockers and cross-sex hormones before age 18. As a practical matter, then, a decision about social transition for a child must be made in light of what is known and what is unknown about the effects of those expected hormonal interventions.

149. I discuss safety considerations in Section IX below. Here, I detail what is known about the effectiveness of social and hormonal transition and affirmation to improve the mental health of individuals diagnosed with gender dysphoria.

B. Youth who adopt a transgender identity show no durable improvement in mental health after social, hormonal, or surgical transition and affirmation.

150. As I noted above, the evidence reviews for the efficacy and safety of hormonal interventions published in 2020 concluded that the supporting evidence is so poor that there is “a

high likelihood that the patient will not experience the hypothesized benefits of the treatment." There is now some concrete evidence that on average they do not experience those benefits.

151. An important paper published in 2021 by Tavistock clinic clinicians provided the results of the first longitudinal study that measured widely used metrics of general psychological function and suicidality before commencement of puberty blockers, and then at least annually after commencing puberty blockers. After up to three years, they "found no evidence of change in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalizing or externalizing problems or self-harm" as compared to the pre-puberty-blocker baseline evaluations. "Outcomes that were not formally tested also showed little change." (Carmichael at al. 2021 at 18-19.) Similarly, a study by Branström and Pachankis of the case histories of a set of individuals diagnosed with GD in Sweden found no positive effect on mental health from hormonal treatment. (Landen 2020.)

152. A cohort study by authors from Harvard and Boston Children's Hospital found that youth and young adults (ages 12-29) who self-identified as transgender had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater proportion of transgender youth accessed inpatient mental health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services. (Reisner et al. 2015 at 6.) Similarly, a recent longitudinal study of transgender and gender diverse youth and young adults in Chicago found rates of alcohol and substance abuse "substantially higher than those reported by large population-based studies of youth and adults." (Newcomb et al. 2020 at 14.) Members of the clinical and research team at the prominent Dutch VU University gender dysphoria center recently compared mental

health metrics of two groups of subjects before (mean age 14.5) and after (mean age 16.8) puberty blockers. But they acknowledged that the structure of their study meant that it "can . . . not provide evidence about . . . long-term mental health outcomes," and that based on what continues to be extremely limited scientific data, "Conclusions about the long-term benefits of puberty suppression should . . . be made with extreme caution." In other words, we just don't know. (van der Miesen et al. 2020 at 703.)

153. Kiera Bell, who was diagnosed with gender dysphoria at the Tavistock Clinic, given cross-sex hormones, and subjected to a mastectomy, before desisting and reclaiming her female gender identity, and a Swedish teen girl who appeared in a recent documentary after walking that same path, have both stated that they feel that they were treated "like guinea pigs," experimental subjects. They are not wrong.

C. Long-term mental health outcomes for individuals who persist in a transgender identity are poor.

154. The responsible MHP cannot focus narrowly on the short-term happiness of the young patient, but must instead consider the happiness and health of the patient from a "life course" perspective. When we look at the available studies of individuals who continue to inhabit a transgender identity across adult years, the results are strongly negative.

155. In the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than expected. These crude death rates include significantly elevated rates of substance abuse as well as suicide. (Levine 2017 at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period. (Dhejne et al. 2011; Simonsen et al. 2016.) The Swedish follow-up study similarly found a suicide rate in the post-SRS population

19.1 times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine 2017 at 10.)

156. A recent study in the American Journal of Psychiatry reported high mental health utilization patterns of adults for ten years after surgery for approximately 35% of patients. (Bränström & Panchankis, 2020.) Indeed, earlier Swedish researchers in a long-term study of all patients provided with SRS over a 30-year period (median time since SRS of > 10 years) concluded that individuals who have SRS exhibit such poor mental health that they should be provided very long-term psychiatric care as the "final" transition step of SRS. (Dhejne et al. 2011, at 6-7.) Unfortunately, across the succeeding decade, in Sweden and elsewhere their suggestion has been ignored.

157. I will note that these studies do not tell us whether the subjects first experienced gender dysphoria as children, adolescents, or adults, so we cannot be certain how their findings apply to each of these subpopulations which represent quite different pathways. But in the absence of knowledge, we should be cautious.

158. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25 or older than does "watchful waiting" or ordinary therapy.

159. The many studies that I have cited here warn us that as we look ahead to the patient's life as a young adult and adult, the prognosis for the physical health, mental health, and social well-being of the child or adolescent who transitions to live in a transgender identity is not good. Gender dysphoria is not "easily managed" when one understands the marginalized, vulnerable physical, social, and psychological status of adult trans populations.

VIII. TRANSITION AND AFFIRMATION DO NOT DECREASE, AND MAY INCREASE, THE RISK OF SUICIDE.

A. The risk of suicide among transgender youth is confused and exaggerated in the public mind.

160. While suicide is closely linked to mental health, I comment on it separately because rhetoric relating to suicide figures so prominently in debates about responses to gender dysphoria.

161. At the outset, I will note that any discussion of suicide when considering younger children involves very long-range and very uncertain prediction. Suicide in pre-pubescent children is extremely rare, and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. Any suggestion otherwise is misinformed. Our focus for this topic, then, is on adolescents and adults.

162. Some authors have reported rates of suicidal thoughts and behaviors among trans-identifying teens or adults ranging from 25% to as high as 52%, generally through non-longitudinal self-reports obtained from non-representative survey samples. (Toomey et al. 2018.) Dr. Adkins asserted in her declaration submitted in support of Plaintiff's preliminary injunction motion that "Attempted suicide rates in the transgender community are over 40%," and that "[t]he only treatment to avoid this serious harm is to . . . affirm gender identity." (Adkins at 6.) Contrary to these assertions, no studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a "watchful waiting" or a psychotherapeutic model of response, as I have described above. Rhetorical references to figures such as 40%—and some published studies—confuse suicidal thoughts and actions that represent a cry for help, manipulation, or expression of rage with serious attempts to end life. Such statements or studies ignore a crucial and long-recognized distinction.

163. I have included suicidality in my discussion of mental health above. Here, I focus on actual suicide. Too often, in public comment suicidal thoughts are blurred with suicide. Yet the available data tells us that suicide among children and youth suffering from gender dysphoria is extremely rare.

164. An important new analysis of data covering patients as well as those on the waiting list (and thus untreated) at the UK Tavistock gender clinic—the world's largest gender clinic—found a total of only four completed suicides across 11 years' worth of patient data, reflecting an estimated cumulative 30,000 patient-years spent by patients under the clinic's care or on its waiting list. This corresponded to an annual suicide rate of 0.013%. The proportion of individual patients who died by suicide was 0.03%, which is orders of magnitude smaller than trans adolescents who self-report suicidal behavior or thoughts on surveys. (Biggs 2022b.)

165. Thus, only a minute fraction of trans-identifying adolescents who report thoughts or conduct considered to represent "suicidality" actually commit suicide. I agree with the statement by Dr. Zucker that the assertion by, for example, Karasic and Ehrensaft (2015) that completed suicides among transgender youth are "alarmingly high" "has no formal and systematic empirical basis." (Zucker 2019 at 3.)

166. Professor Biggs of Oxford, author of the study of incidence of suicide among Tavistock clinic patients, rightly cautions that it is "irresponsible to exaggerate the prevalence of suicide." (Biggs 2022b at 4.) It is my opinion that telling parents—or even allowing them to believe from their internet reading—that they face a choice between "a live son or a dead daughter" is both factually wrong and unethical. Informed consent requires clinicians to tell the truth and ensure that their patients understand the truth. To be kind, the clinicians who believe

such figures represent high risk of ultimate suicide in adolescence simply do not know the truth; they are ill-informed.

B. Transition of any sort has not been shown to reduce levels of suicide.

167. Every suicide is a tragedy, and steps that reduce suicide should be adopted. I have noted above that suicidality (that is, suicidal thoughts or behaviors, rather than suicide) is common among transgender adolescents and young adults before, during, and after social and medical transition. If a medical or mental health professional believes that an individual he or she is diagnosing or treating for gender dysphoria presents a suicide risk, in my view it is unethical for that professional merely to proceed with treatment for gender dysphoria and hope that "solves the problem." Rather, that professional has an obligation to provide or refer the patient for evidence-based therapies for addressing depression and suicidal thoughts that are well-known to the profession. (Levine 2016 at 242.)

168. This is all the more true because there is in fact no evidence that social and/or medical transition reduces the risk or incidence of actual suicide. On the contrary, in his analysis of those who were patients of or on the waiting list of the Tavistock clinic, Professor Biggs found that the suicide rate was not higher among those on the clinic's waiting list (and thus as-yet untreated), than for those who were patients under care. (Biggs 2022b.) And as corrected, Bränström and Pachankis similarly acknowledge that their review of records of GD patients "demonstrated no advantage of surgery in relation to . . . hospitalizations following suicide attempts." (I assume for this purpose that attempts that result in hospitalization are judged to be so serious as to predict a high rate of future suicide if not successfully addressed.")[11]

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[11] Turban et al. (2020) has been described in press reports as demonstrating that administration of puberty suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

C. Long-term life in a transgender identity correlates with very high rates of completed suicide.

169. As with mental health generally, the patient, parent, or clinician fearing the risk of suicide must consider not just the next month or year, but a life course perspective.

170. There are now four long-term studies that analyze completed suicide among those living in transgender identities into adulthood. The results vary significantly, but are uniformly highly negative.

171. Dhejne reported a long-term follow-up study of subjects after sex reassignment surgery. Across the multi-year study, subjects who had undergone SRS committed suicide at 19.1 times the expected rate compared to general population controls matched by age and both sexes. MtF subjects committed suicide at 13.9 times the expected rate, and FtM subjects committed suicide at 40.0 times the expected rate. (Dhejne et al. 2011 Supplemental Table S1.)

172. Asscheman, also writing in 2011, reported results of a long-term follow-up of all transsexual subjects of the Netherlands' leading gender medicine clinic who started cross-sex hormones before July 1, 1997, a total of 1331 patients. Due to the Dutch system of medical and death records, extensive follow-up was achieved. Median follow-up period was 18.5 years. The mortality rate among MtF patients was 51% higher than among the age-matched general population; the rate of completed suicide among MtF patients was six times that of the age-matched general population. (Asscheman et al. 2011.)

173. Importantly, Asscheman et al. found that "No suicides occurred within the first 2 years of hormone treatment, while there were six suicides after 2-5 years, seven after 5-10 years, and four after more than 10 years of CSH treatment at a mean age of 41.5 years." (Asscheman et al. 2011 at 637-638.) This suggests that studies that follow patients for only a year or two after treatment are insufficient. Asscheman et al.'s data suggest that such short-term follow-up is

engaging only with an initial period of optimism, and will simply miss the feelings of disillusion and the increase in completed suicide that follows in later years.

174. A retrospective, long-term study published in 2020 of a very large cohort (8263) of patients referred to the Amsterdam University gender clinic between 1972 and 2017 found that the annual rate of completed suicides among the transgender subjects was "three to four times higher than the general Dutch population." "[T]he incidence of observed suicide deaths was almost equally distributed over the different stages of treatment." The authors concluded that "vulnerability for suicide occurs similarly in the different stages of transition." (Wiepjes et al. 2020.) In other words, neither social nor medical transition reduced the rate of suicide.

175. As with Asscheman et al., Wiepjes et al. found that the median time between start of hormones and suicide (when suicide occurred) was 6.1 years for natal males, and 6.9 years for natal females. Again, short- or even medium-term studies will miss this suicide phenomenon.

176. A 2021 study analyzed the case histories of a cohort of 175 gender dysphoria patients treated at one of the seven UK adult gender clinics who were "discharged" (discontinued as patients) within a selected one-year period. The authors reported the rather shocking result that 7.7% (3/39) of natal males who were diagnosed and admitted for treatment, and who were between 17 and 24 years old, were "discharged" because they committed suicide ***during* treatment**. (Hall et al. 2021, Table 2.)

177. None of these studies demonstrates that the hormonal or surgical intervention *caused* suicide. That is possible, but as we have seen, the population that identifies as transgender suffers from a high incidence of comorbidities that correlate with suicide. What these studies demonstrate—at the least—is that this remains a troubled population in need of extensive and careful psychological care that they generally do not receive, and that neither

hormonal nor surgical transition and "affirmation" resolve their underlying problems and put them on the path to a stable and healthy life.

178. In sum, claims that affirmation will reduce the risk of suicide for children and adolescents are not based on science. Instead, transition of any sort must be justified, if at all, as a life-enhancing measure, not a lifesaving measure. (Levine 2016 at 242.) In my opinion, this is an important fact that patients, parents, and even many MHPs fail to understand.

IX. HORMONAL INTERVENTIONS ARE EXPERIMENTAL PROCEDURES THAT HAVE NOT BEEN PROVEN SAFE.

179. Dr. Adkins also appears to assert as a fact—but without citation to peer-reviewed literature—that social transition, puberty blockers, and cross-sex hormones are known to be "safe." (Adkins at 5-6, 8.) This is not true. And Dr. Adkins, along with a number of voices in the field, also asserts that puberty blockers act merely as a "pause" in the process of puberty-driven maturation, suggesting that this hormonal intervention has been proven to be fully reversible. This is also an unproven belief.

180. On the contrary, no studies have been done that meaningfully demonstrate that either puberty blockers or cross-sex hormones, as prescribed for gender dysphoria, are safe in other than the short run. No studies have attempted to determine whether the effects of puberty blockers, as currently being prescribed for gender dysphoria, are fully reversible. Neither Dr. Adkins nor Dr. Safer cites any such studies, and there are none. There are only pronouncements. In fact, there are substantial reasons for concern that these hormonal interventions are not safe. Multiple researchers have expressed concern that the full range of possible harms have not even been correctly conceptualized.

181. Because, as I have explained in Section VI, recent evidence demonstrates that pre-pubertal social transition almost always leads to progression on to puberty blockers which in turn

almost always leads to the use of cross-sex hormones, physicians bear the ethical responsibility for a thorough informed consent process for parents and patients that includes this fact and its full implications. Informed consent does not mean sharing with the parents and patients what the doctor believes: it means sharing what is known and what is not known about the intervention. So much of what doctors believe is based on mere trust in what they have been taught. Neither they themselves nor their teachers may be aware of the scientific foundation and scientific limitations of what they are recommending.

A. Use of puberty blockers has not been shown to be safe or reversible for gender dysphoria.

182. As I noted above, the recent very thorough literature review performed for the British NHS concluded that *all* available clinical evidence relating to "safety outcomes" from administration of puberty blockers for gender dysphoria is of "very low certainty." (NHS 2020a at 6.)

183. In its 2017 Guidelines, the Endocrine Society cautioned that "in the future we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols" including "careful assessment of . . . the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development)." (Hembree et al. 2017 at 3874.) No such "careful" or "rigorous" evaluation of these very serious safety questions has yet been done.

184. Some advocates appear to assume that puberty blockers are "safe" because they have been approved by the Food and Drug Administration (FDA) for use to treat precocious puberty—a rare condition in which the puberty process may start at eight or younger. No such conclusion can be drawn. As the "label" for Lupron (one of the most widely prescribed puberty blockers) explains, the FDA approved the drug only *until* the "age was appropriate for entry into

puberty." The study provides no information at all as to the safety or reversibility of instead *blocking* healthy, normally-timed puberty's beginning, and *throughout* the years that body-wide continuing changes normally occur. Given the physical, social, and psychological dangers to the child with precocious puberty, drugs like Lupron are effective in returning the child to a puerile state without a high incidence of significant side effects—that is, they are "safe" to reverse the condition. But use of drugs to suppress normal puberty has multiple organ system effects whose long-term consequences have not been investigated.

185. **Fertility**: The Endocrine Society Guidelines rightly say that research is needed into the effect of puberty blockade on "gonadal function" and "sexual development." The core purpose and function of puberty blockers is to prevent the maturation of the ovaries or testes, the sources of female hormones and male hormones when stimulated by the pituitary gland. From this predictable process fertility is accomplished within a few years. Despite widespread assertions that puberty blockers are "fully reversible," there has been no study published on the critical question of whether patients ever develop normal levels of fertility if puberty blockers are terminated after a "prolonged delay of puberty." The 2017 Endocrine Society Guidelines are correct that are no data on achievement of fertility "following prolonged gonadotropin suppression" (that is, puberty blockade). (Hembree et al. 2017 at 3880.)

186. **Bone strength**: Multiple studies have documented adverse effects from puberty blockers on bone density. (Klink et al. 2015; Vlot et al. 2016; Joseph et al. 2019.) The most recent found that after two years on puberty blockers, the bone density measurements for a significant minority of the children had declined to clinically concerning levels. Density in the spines of some subjects fell to a level found in only 0.13% of the population. (Biggs 2021.) Some

other studies have found less concerning effects on bone density. While the available evidence remains limited and conflicting, it is not possible to conclude that the treatment is "safe."

187. **Brain development:** Important neurological growth and development in the brain occurs across puberty. The anatomic and functional effect on brain development of blocking the natural puberty process has not been well studied. A prominent Australian clinical team recently expressed concern that "no data were (or are) available on whether delaying the exposure of the brain to a sex steroid affects psychosexual, cognitive, emotional, or other neuropsychological maturation." (Kozlowska et al. 2021 at 89.) In my opinion, given the observed correlation between puberty and brain development, the default hypothesis must be that there *would* be a negative impact. For the purpose of protecting patients all over the world, the burden of proof should be on advocates to first demonstrate to a reasonable degree of certainty that brain structure and its measurable cognitive and affect processing are not negatively affected. This recalls the ethical principle: Above All Do No Harm.

188. The Endocrine Society Guidelines acknowledge as much, stating that side effects of pubertal suppression "may include . . . unknown effects on brain development," that "we need more rigorous evaluations of . . . the effects of prolonged delay of puberty in adolescents on . . . the brain (including effects on cognitive, emotional, social, and sexual development)," and stating that "animal data suggests there may be an effect of GnRH analogs [puberty blockers] on cognitive function." (Hembree et al. 2017 at 3874, 3882, 3883.) Given this concern, one can only wonder why this relevant question has not been scientifically investigated in a large group of natal males and females.

189. There has been a longitudinal study of one natal male child, assessed before, and again 20 months after, puberty suppression was commenced. It reported a reduction in the

patient's "global IQ," measured an anomalous absence of certain structural brain development expected during normal male puberty, and hypothesized that "a plausible explanation for the G[lobal] IQ decrease should consider a disruption of the synchronic [i.e., appropriately timed] development of brain areas by pubertal suppression." (Schneider et al. 2017 at 7.) This should cause parents and practitioners serious concern.

190. Whether any impairment of brain development is "reversed" upon later termination of puberty blockade has, to my knowledge, not been studied at all. As a result, assertions by medical or mental health professionals that puberty blockade is "fully reversible" are unjustified and based on hope rather than science.

191. Without a number of additional case studies—or preferably statistically significant clinical studies—two questions remain unanswered: Are there brain anatomic or functional impairment from puberty blockers? And are the documented changes reversed over time when puberty blockers are stopped? With these questions unanswered, it is impossible to assert with certainty that the effects of this class of medications are "fully reversible." Such an assertion is another example of ideas based on beliefs rather than on documentation, on hope not science.

192. **Psycho-social harm**: Puberty is a time of stress, anxiety, bodily discomfort during physical development, and identity formation for *all* humans. No careful study has been done of the long-term impact on the young person's coping skills, interpersonal comfort, and intimate relationships from remaining puerile for, e.g., two to five years while one's peers are undergoing pubertal transformations, and of then undergoing an artificial puberty at an older age. However, pediatricians and mental health professionals hear of distress, concern, and social awkwardness in those who naturally have a delayed onset of puberty. In my opinion, individuals

in whom puberty is delayed multiple years are likely to suffer at least subtle negative psychosocial and self-confidence effects as they stand on the sidelines witnessing their peers developing the social relationships (and attendant painful social learning experiences) that come with adolescence. (Levine 2018 at 9.) Social anxiety and social avoidance are common findings in the evaluation of trans-identified children and teens. Are we expected to believe that creating years of being further different than their peers has no lasting internal consequences? Do we ignore Adolescent Psychiatry's knowledge of the importance of peer groups among adolescents?

193. We simply do not know what all the psychological impacts of NOT grappling with puberty at the ordinary time may be, because it has not been studied. And we have no information as to whether that impact is "fully reversible."

194. In addition, since the overwhelming proportion of children who begin puberty blockers continue on to cross-sex hormones, it appears that there is an important element of "psychological irreversibility" in play. The question of to what extent the physical and developmental impacts of puberty blockers might be reversible is an academic one, if psycho-social realities mean that very few patients well ever be able to make that choice once they have started down the road of social transition and puberty blockers.

B. Use of cross-sex hormones in adolescents for gender dysphoria has not been shown to be medically safe except in the short term.

195. As with puberty blockers, all evidence concerning the safety of extended use of cross-sex hormones is of "very low quality." The U.K. NICE evidence review cautioned that "the safety profiles" of cross-sex hormone treatments are "largely unknown," and that several of the limited studies that do exist reported high numbers of subjects "lost to follow-up," without explanation—a worrying indicator. (NICE 2020b.)

196. The 2020 Cochrane Review reported that: "We found insufficient evidence to determine the . . . safety of hormonal treatment approaches for transgender women in transition." (Haupt et al. 2020 at 4.) Even the Endocrine Society tagged all its recommendations for the administration of cross-sex hormones as based on "low quality evidence." (Hembree et al. 2017 at 3889.)

197. **Sterilization**: It is undisputed, however, that harm to the gonads is an expected effect, to the extent that it must be assumed that cross-sex hormones will sterilize the patient. Thus, the Endocrine Society 2017 Guidelines caution that "[p]rolonged exposure of the testes to estrogen has been associated with testicular damage," that "[r]estoration of spermatogenesis after prolonged estrogen treatment has not been studied," and that "[i]n biological females, the effect of prolonged treatment with exogenous testosterone upon ovarian function is uncertain." (Hembree et al. 2017 at 3880.) [12]

198. The Guidelines go on to recommend that the practitioner counsel the patient about the (problematic and uncertain) options available to collect and preserve fertile sperm or ova before beginning cross-sex hormones. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been studied specifically within the transgender population, the opportunity to be a parent is likely a human, emotional need, and so should be considered an important risk factor when considering gender transition for any patient.

[12] *See also* Guss et al. 2015 at 4 ("a side effect [of cross-sex hormones] may be infertility") and at 5 ("cross-sex hormones . . . may have irreversible effects"); Tishelman et al. 2015 at 8 (Cross-sex hormones are "irreversible interventions" with "significant ramifications for fertility").

199. **Sexual response**: Puberty blockers prevent maturation of the sexual organs and response. Some, and perhaps many, transgender individuals who did not go through puberty consistent with their sex and are then put on cross-sex hormones face significantly diminished sexual response as they enter adulthood and are unable ever to experience orgasm. In the case of males, the cross-sex administration of estrogen limits penile genital growth and function. In the case of females, prolonged exposure to exogenous testosterone impairs vaginal function. Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that is ultimately applicable to the transgendered. (Levine 2018 at 6.) At the same time, prolonged exposure of females to exogenous testosterone often increases sexual drive to a distracting degree. It is likely that parents and physicians are uncomfortable discussing any aspects of genital sexual activity with patients.

200. **Cardiovascular harm**: Several researchers have reported that cross-sex hormones increase the occurrence of various types of cardiovascular disease, including strokes, blood clots, and other acute cardiovascular events. (Getahun et al. 2018; Guss et al. 2015; Asscheman et al. 2011.) With that said, I agree with the conclusion of the Endocrine Society committee (like that of the NICE Evidence Review) that: “A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or venous thromboembolism in transgender males. Future research is needed to ascertain the potential harm of hormonal therapies.” (Hembree et al. 2017 at 3891.) Future research questions concerning long-term harms need to be far more precisely defined. The question of whether cross-sex hormones are safe for adolescents and young adults cannot be answered by analogies to hormone replacement therapy in menopausal women (which is not a cross-sex usage).

Medicine has answered safety questions for menopausal women in terms of cancer and cardiovascular safety: at what dose, for what duration, and at what age range. The science of endocrine treatment of gender dysphoric youth is being bypassed by short-term clinical impressions of safety even though physicians know that cardiovascular and cancer processes often develop over many years.

201. Further, in contrast to administration for menopausal women, hormones begun in adolescence are likely to be administered for four to six decades. The published evidence of adverse impact, coupled with the lack of data sufficient to reach a firm conclusion, make it irresponsible to assert that cross-sex hormones "are safe."

202. **Harm to family and friendship relationships:** As a psychiatrist, I recognize that mental health is a critical part of health generally, and that relationships cannot be separated from and profoundly impact mental health. Gender transition routinely leads to isolation from at least a significant portion of one's family in adulthood. In the case of a juvenile transition, this will be less dramatic while the child is young, but commonly increases over time as siblings who marry and have children of their own do not wish the transgender individual to be in contact with those children. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often "virtual" friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals. (Levine 2017 at 5.) My concerns about this are based on decades of observations in my professional work with patients.

203. **Sexual-romantic harms associated with transition:** After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished. When a trans person who passes well reveals his or her natal sex, many potential mates lose interest. When a trans person does not pass well,

options are likely further diminished. But regardless of a person's appearance, these adults soon learn that many of their dates are looking for exotic sexual experiences rather than genuinely loving relationships. (Levine 2017 at 5, 13; Levine 2013 at 40.)

C. The timing of harms.

204. The multi-year delay between start of hormones and the spike in completed suicide observed by Professor Biggs in the Tavistock data (as discussed in Section VIII above) warns us that the safety and beneficence of these treatments cannot be judged based on short-term studies, or studies that do not continue into adulthood. Similarly, several of the harms that I discuss above would not be expected to manifest until the patients reaches at least middle-age. For example, stroke or other serious cardiovascular event is a complication that is unlikely to manifest during teen years even if its likelihood over the patient's lifetime has been materially increased via obesity, lipid abnormalities, and smoking. Regret over sterilization or over an inability to form a stable romantic relationship may occur sooner. Psychological challenges of being a trans adult may become manifest after the medical profession is only doing routine follow up care—or, in many cases, has lost contact with the patient altogether. Because few, if any, clinics in this country are conducting systematic long-term follow-up with their child and adolescent patients, the doctors who counsel, prescribe, or perform hormonal and surgical therapies are unlikely ever to become aware of the later negative life impacts, however severe. These concerns are compounded by the findings in the recent "detransitioner" research that 76% did not inform their clinicians of their detransition. (Littman 2021.)

205. The possibility that steps along the transition and affirmation pathway, while lessening the pain of gender dysphoria in the short term, could lead to additional sources of crippling emotional and psychological pain, are too often not considered by advocates of social transition and not considered at all by the trans child. (Levine 2016 at 243.) Clinicians must

distinguish the apparent short-term safety of hormones from likely or possible long-term consequences, and help the patient or parents understand these implications as well. The young patient may feel, “I don’t care if I die young, just as long I get to live as a woman.” The mature adult may take a different view. Hopefully, so will the child’s physician.

206. Individual patients often pin excessive hope in transition, believing that transition will solve what are in fact ordinary social stresses associated with maturation, or mental health co-morbidities. In this way, transition can prevent them from mastering personal challenges at the appropriate time or directly addressing conditions that require treatment. When the hoped-for “vanishing” of other mental health or social difficulties does not occur, disappointment, distress, and depression may ensue. It is noteworthy that half of the respondents to the larger “detransitioner” survey reported that their transition had not helped the gender dysphoria, and 70% had concluded that their gender dysphoria was related to other issues. (Vandenbussche 2021.) Without the clinical experience of monitoring the psychosocial outcomes of these young patients as they age into adulthood, many such professionals experience no challenge to their affirmative beliefs. But medical and mental health professionals who deliver trans affirmative care for those with previous and co-existing mental health problems have an ethical obligation to inform themselves, and to inform patients and parents, that these dramatic treatments are not a panacea.

207. In sum, whether we consider physical or mental health, science does not permit us to say that either puberty blockers or cross-sex hormones are “safe,” and the data concerning the mental health of patients before, during, and after such treatments strongly contradict the assertion that gender dysphoria is “easily managed.”

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Zucker, K. (2019). *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*. ARCHIVES OF SEXUAL BEHAVIOR 48(7) 1983–1992.

Zucker, K. (2020). *Different strokes for different folks.* CHILD ADOLESC MENT HEALTH 25(1): 36–37. https://doi: 10.1111/camh.12330.

LEVINE EXPERT REPORT

EXHIBIT A

Stephen B. Levine, M.D. Curriculum Vita
February, 2022

Brief Introduction

Dr. Levine is Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the author or coauthor of numerous books on topics relating to human sexuality and related relationship and mental health issues. Dr. Levine has been teaching, providing clinical care, and writing since 1973, and has generated original research, invited papers, commentaries, chapters, and book reviews. He has served as a journal manuscript and book prospectus reviewer for many years. Dr. Levine has been co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992 to the present. He received a lifetime achievement Masters and Johnson's Award from the Society for Sex Therapy and Research in March 2005.

Personal Information

Date of birth 1/14/42

Medical license no. Ohio 35-03-0234-L

Board Certification 6/76 American Board of Neurology and Psychiatry

Education

1963 BA Washington and Jefferson College

1967 MD Case Western Reserve University School of Medicine

1967-68 internship in Internal Medicine University Hospitals of Cleveland

1968-70 Research associate, National Institute of Arthritis and Metabolic Diseases, Epidemiology Field Studies Unit, Phoenix, Arizona, United States Public Health Service

1970-73 Psychiatric Residency, University Hospitals of Cleveland

1974-77 Robert Wood Johnson Foundation Clinical Scholar

Appointments at Case Western Reserve University School of Medicine

1973- Assistant Professor of Psychiatry

1979- Associate Professor

1982- Awarded tenure

1985- Full Professor

1993- Clinical Professor

Honors

Summa Cum Laude, Washington & Jefferson

Teaching Excellence Award-1990 and 2010 (Residency program)

Visiting Professorships

- Stanford University-Pfizer Professorship program (3 days)–1995
- St. Elizabeth's Hospital, Washington, DC –1998
- St. Elizabeth's Hospital, Washington, DC--2002

Named to America's Top Doctors consecutively since 2001

Invitations to present various Grand Rounds at Departments of Psychiatry and Continuing Education Lectures and Workshops

Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research, April 2005 along with Candace Risen and Stanley Althof

2006 SSTAR Book Award for The Handbook of Clinical Sexuality for Mental Health Professionals: Exceptional Merit

2018—Albert Marquis Lifetime Achievement Award from Marquis Who's Who. (Exceling in one's field for at least twenty years)

Professional Societies

1971- American Psychiatric Association; fellow; #19909

2005- American Psychiatric Association, Distinguished Life Fellow

1973- Cleveland Psychiatric Society

1973- Cleveland Medical Library Association

- 1985 - Life Fellow
- 2003 - Distinguished Life Fellow

1974-Society for Sex Therapy and Research

- 1987-89-President

1983- International Academy of Sex Research

1983- Harry Benjamin International Gender Dysphoria Association

- 1997-8 Chairman, Standards of Care Committee

1994- 1999 Society for Scientific Study of Sex

Community Boards

1999-2002 Case Western Reserve University Medical Alumni Association

1996-2001 Bellefaire Jewish Children's Bureau

1999-2001 Physicians' Advisory Committee, The Gathering Place (cancer rehabilitation)

Editorial Boards

1978-80 Book Review Editor Journal Sex and Marital Therapy

Manuscript Reviewer for:

a. Archives of Sexual Behavior
b. Annals of Internal Medicine
c. British Journal of Obstetrics and Gynecology
d. JAMA
e. Diabetes Care
f. American Journal of Psychiatry
g. Maturitas
h. Psychosomatic Medicine
i. Sexuality and Disability
j. Journal of Nervous and Mental Diseases
k. Journal of Neuropsychiatry and Clinical Neurosciences
l. Neurology
m. Journal Sex and Marital Therapy
n. Journal Sex Education and Therapy
o. Social Behavior and Personality: an international journal (New Zealand)
p. International Journal of Psychoanalysis
q. International Journal of Transgenderism
r. Journal of Urology
s. Journal of Sexual Medicine
t. Current Psychiatry
u. International Journal of Impotence Research
v. Postgraduate medical journal
w. Academic Psychiatry

Prospectus Reviewer

a. Guilford

b. Oxford University Press

c. Brunner/Routledge

d. Routledge

Administrative Responsibilities

Principal Investigator of approximately 70 separate studies involving pharmacological interventions for sexual dysfunction since 1989.

Co-leader of case conferences at DELRLLC.com

Expert testimony at trial or by deposition within the last 4 years

Provided expert testimony for Massachusetts Dept. of Corrections in its defense of a lawsuit brought by prisoner Katheena Soneeya, including by deposition in October 2018, and in-court testimony in 2019.

Provided expert testimony by deposition and at trial in *In the Interests of the Younger Children* (Dallas, TX), 2019.

Testified in an administrative hearing in *In the matter of Rhys & Lynn Crawford* (Washington State), March 2021.

Testified multiple times in juvenile court in *In the matter of Asha Kerwin* (Tucson, Arizona), 2021.

Provided expert testimony by deposition in *Kadel et al v. Folwell et al.* (North Carolina), 2021.

Consultancies

Massachusetts Department of Corrections—evaluation of 12 transsexual prisoners and the development of a Gender Identity Disorders Program for the state prison system. Monthly consultation with the GID treatment team since February 2009 and the GID policy committee since February 2010.

California Department of Corrections and Rehabilitation; 2012-2015; education, inmate evaluation, commentary on inmate circumstances, suggestions on future policies.

Virginia Department of Corrections –evaluation of an inmate.

New Jersey Department of Corrections—evaluation of an inmate.

Idaho Department of Corrections—workshop 2016.

Grant Support/Research Studies

TAP–studies of Apomorphine sublingual in treatment of erectile dysfunction.

Pfizer–Sertraline for premature ejaculation.

Pfizer–Viagra and depression; Viagra and female sexual dysfunction; Viagra as a treatment for SSRI-induced erectile dysfunction.

NIH- Systemic lupus erythematosis and sexuality in women.

Sihler Mental Health Foundation

a. Program for Professionals
b. Setting up of Center for Marital and Sexual Health
c. Clomipramine and Premature ejaculation
d. Follow-up study of clergy accused of sexual impropriety
e. Establishment of services for women with breast cancer

Alza–controlled study of a novel SSRI for rapid ejaculation.

Pfizer–Viagra and self-esteem.

Pfizer- double-blind placebo control studies of a compound for premature ejaculation.

Johnson & Johnson – controlled studies of Dapoxetine for rapid ejaculation.

Proctor and Gamble: multiple studies to test testosterone patch for post menopausal sexual dysfunction for women on and off estrogen replacement.

Lilly-Icos—study of Cialis for erectile dysfunction.

VIVUS – study for premenopausal women with FSAD.

Palatin Technologies- studies of bremelanotide in female sexual dysfunction—first intranasal then subcutaneous administration.

Medtap – interview validation questionnaire studies.

HRA- quantitative debriefing study for Female partners os men with premature ejaculation, Validation of a New Distress Measure for FSD.

Boehringer-Ingelheim- double blind and open label studies of a prosexual agent for hypoactive female sexual desire disorder.

Biosante- studies of testosterone gel administration for post menopausal women with HSDD.

J&J a single-blind, multi-center, in home use study to evaluate sexual enhancement effects of a product in females.

UBC-Content validity study of an electronic FSEP-R and FSDS-DAO and usability of study PRO measures in premenopausal women with FSAD, HSDD or Mixed FSAD/HSDD.

National registry trial for women with HSDD.

Endoceutics—two studies of DHEA for vaginal atrophy and dryness in post menopausal women.

Palatin—study of SQ Bremelanotide for HSDD and FSAD.

Trimel- a double-blind, placebo controlled study for women with acquired female orgasmic disorder.

S1 Biopharma- a phase 1-B non-blinded study of safety, tolerability and efficacy of Lorexys in premenopausal women with HSDD.

HRA – qualitative and cognitive interview study for men experiencing PE.

Publications

A) Books

1) Pariser SR, Levine SB, McDowell M (eds.), Clinical Sexuality, Marcel Dekker, New York, 1985

2) Sex Is Not Simple, Ohio Psychological Publishing Company, 1988; Reissued in paperback as: Solving Common Sexual Problems: Toward a Problem Free Sexual Life, Jason Aronson, Livingston, NJ. 1997

3) Sexual Life: A Clinician's Guide. Plenum Publishing Corporation. New York, 1992

4) Sexuality in Midlife. Plenum Publishing Corporation. New York, 1998

5) Editor, Clinical Sexuality. Psychiatric Clinics of North America, March, 1995.

6) Editor, (Candace Risen and Stanley Althof, associate editors) Handbook of Clinical Sexuality for Mental Health Professionals. Routledge, New York, 2003

1. 2006 SSTAR Book Award: Exceptional Merit

7) Demystifying Love: Plain Talk For The Mental Health Professional. Routledge, New York, 2006

8) Senior editor, (Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals, 2nd edition. Routledge, New York, 2010.

9) Barriers to Loving: A Clinician's Perspective. Routledge, New York, 2014.

10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3rd edition Routledge, New York, 2016

B) Research and Invited Papers

When his name is not listed in a citation, Dr. Levine is either the solo or the senior author.

1) Sampliner R. Parotid enlargement in Pima Indians. Annals of Internal Medicine 1970; 73:571-73

2) Confrontation and residency activism: A technique for assisting residency change: World Journal of Psychosynthesis 1974; 6: 23-26

3) Activism and confrontation: A technique to spur reform. Resident and Intern Consultant 173; 2

4) Medicine and Sexuality. Case Western Reserve Medical Alumni Bulletin 1974:37:9-11.

5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334

6) Marital Sexual Dysfunction: Introductory Concepts. Annals of Internal Medicine 1976;84:448-453

7) Marital Sexual Dysfunction: Ejaculation Disturbances 1976; 84:575-579

8) Yost MA: Frequency of female sexual dysfunction in a gynecology clinic: An epidemiological approach. Archives of Sexual Behavior 1976;5:229-238

9) Engel IM, Resnick PJ, Levine SB: Use of programmed patients and videotape in teaching medical students to take a sexual history. Journal of Medical Education 1976;51:425-427

10) Marital Sexual Dysfunction: Erectile dysfunction. Annals of Internal Medicine 1976;85:342-350

11) Male Sexual Problems. Resident and Staff Physician 1981:2:90-5

12) Female Sexual Problems. Resident and Staff Physician 1981:3:79-92

13) How can I determine whether a recent depression in a 40 year old married man is due to organic loss of erectile function or whether the depression is the source of the dysfunction? Sexual Medicine Today 1977;1:13

14) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977

15) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597

16) Current problems in the diagnosis and treatment of psychogenic impotence. Journal of Sex & Marital Therapy 1977;3:177-186

17) Resnick PJ, Engel IM. Sexuality curriculum for gynecology residents. Journal of Medical Education 1978; 53:510-15

18) Agle DP. Effectiveness of sex therapy for chronic secondary psychological impotence Journal of Sex & Marital Therapy 1978;4:235-258

19) DePalma RG, Levine SB, Feldman S. Preservation of erectile function after aortoiliac reconstruction. Archives of Surgery 1978;113-958-962

20) Conceptual suggestions for outcome research in sex therapy Journal of Sex & Marital Therapy 1981;6:102-108

21) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113

22) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929

23) Stern RG Sexual function in cystic fibrosis. Chest 1982; 81:422-8

24) Shumaker R. Increasingly Ruth: Towards understanding sex reassignment surgery Archives of Sexual Behavior 1983;12:247-61

25) Psychiatric diagnosis of patients requesting sex reassignment surgery. Journal of Sex & Marital Therapy 1980; 6:164-173

26) Problem solving in sexual medicine I. British Journal of Sexual Medicine 1982;9:21-28

27) A modern perspective on nymphomania. Journal of Sex & Marital Therapy 1982;8:316-324

28) Nymphomania. Female Patient 1982;7:47-54

29) Commentary on Beverly Mead's article: When your patient fears impotence. Patient Care 1982;16:135-9

30) Relation of sexual problems to sexual enlightenment. Physician and Patient 1983 2:62

31) Clinical overview of impotence. Physician and Patient 1983; 8:52-55.

32) An analytical approach to problem-solving in sexual medicine: a clinical introduction to the psychological sexual dysfunctions. II. British Journal of Sexual Medicine

33) Coffman CB, Levine SB, Althof SE, Stern RG Sexual Adaptation among single young adults with cystic fibrosis. Chest 1984;86:412-418

34) Althof SE, Coffman CB, Levine SB. The effects of coronary bypass in female sexual, psychological, and vocational adaptation. Journal of Sex & Marital Therapy 1984;10:176-184

35) Letter to the editor: Follow-up on Increasingly Ruth. Archives of Sexual Behavior 1984;13:287-9

36) Essay on the nature of sexual desire Journal of Sex & Marital Therapy 1984; 10:83-96

37) Introduction to the sexual consequences of hemophilia. Scandanavian Journal of Haemology 1984; 33:(supplement 40).75-

38) Agle DP, Heine P. Hemophila and Acquired Immune Deficiency Syndrome: Intimacy and Sexual Behavior. National Hemophilia Foundation; July, 1985

39) Turner LA, Althof SE, Levine SB, Bodner DR, Kursh ED, Resnick MI.

External vacuum devices in the treatment of erectile dysfunction: a one-year study of sexual and psychosocial impact. Journal of Sex & Marital Therapy

40) Schein M, Zyzanski SJ, Levine SB, Medalie JH, Dickman RL, Alemagno SA. The frequency of sexual problems among family practice patients. Family Practice Research Journal 1988; 7:122-134

41) More on the nature of sexual desire. Journal of Sex & Marital Therapy 1987;13:35-44

42) Waltz G, Risen CB, Levine SB. Antiandrogen treatment of male sex offenders. Health Matrix 1987; V.51-55.

43) Lets talk about sex. National Hemophilia Foundation January, 1988

44) Sexuality, Intimacy, and Hemophilia: questions and answers . National Hemophilia Foundation January, 1988

45) Prevalence of sexual problems. Journal Clinical Practice in Sexuality 1988;4:14-16.

46) Kursh E, Bodner D, Resnick MI, Althof SE, Turner L, Risen CB, Levine SB. Injection Therapy for Impotence. Urologic Clinics of North America 1988; 15(4):625-630

47) Bradley SJ, Blanchard R, Coates S, Green R, Levine S, Meyer-Bahlburg H, Pauly I, Zucker KJ. Interim report of the DSM-IV Subcommittee for Gender Identity Disorders. Archives of Sexual Behavior 1991;;20(4):333-43.

48) Sexual passion in mid-life. Journal of Clinical Practice in Sexuality 1991 6(8):13-19

49) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DR, Resnick MI. Intracavernosal injections in the treatment of impotence: A prospective study of sexual, psychological, and marital functioning. Journal of Sex & Marital Therapy 1987**;** 13:155-167

50) Althof SE, Turner LA, Risen CB, Bodner DR, Kursh ED, Resnick MI. Side effects of self-administration of intracavernosal injection of papaverine and phentolamine for treatment of impotence. Journal of Urology 1989;141:54-7

51) Turner LA, Froman SL, Althof SE, Levine SB, Tobias TR, Kursh ED, Bodner DR. Intracavernous injection in the management of diabetic impotence. Journal of Sexual Education and Therapy 16(2):126-36, 1989

52) Is it time for sexual mental health centers? Journal of Sex & Marital Therapy 1989

53) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Sexual, psychological, and marital impact of self injection of papaverine and phentolamine: a long-term prospective study. Journal of Sex & Marital Therapy

54) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Why do so many men drop out of intracavernosal treatment? Journal of Sex & Marital Therapy. 1989;15:121-9

55) Turner LA, Althof SE, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Self injection of papaverine and phentolamine in the treatment of psychogenic impotence. Journal of Sex & Marital Therapy. 1989; 15(3):163-78

56) Turner LA, Althof SE, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Treating erectile dysfunction with external vacuum devices: impact upon sexual, psychological, and marital functioning. Journal of Urology 1990;141(1):79-82

57) Risen CB, Althof SE. An essay on the diagnosis and nature of paraphilia Journal of Sex & Marital Therapy 1990; 16(2):89-102.

58) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Through the eyes of women: the sexual and psychological responses of women to their partners' treatment with self-injection or vacuum constriction therapy. International Journal of Impotence Research (supplement 2)1990;346-7.

59) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. A comparison of the effectiveness of two treatments for erectile dysfunction: self injection vs. external vacuum devices. . International Journal of Impotence Research (supplement 2)1990;289-90

60) Kursh E, Turner L, Bodner D, Althof S, Levine S. A prospective study on the use of the vacuum pump for the treatment of impotence.International Journal of Impotence Research (supplement 2)1990;340-1.

61) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of intracavernous therapy in the treatment of erectile dysfunction in Journal of Sex & Marital Therapy 1991; 17(2):101-112

62) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of vacuum pump devices in the treatment of erectile dsyfunction in Journal of Sex & Marital Therapy 1991;17(2):81-93

63) Turner LA, Althof SE, Levine SB, Bodner DB, Kursh ED, Resnick MI. A 12-month comparison of the effectiveness of two treatments for erectile dysfunction: self injection vs. external vacuum devices. Urology 1992;39(2):139-44

64) Althof SE, The pathogenesis of psychogenic impotence. J. Sex Education and Therapy. 1991; 17(4):251-66

65) Mehta P, Bedell WH, Cumming W, Bussing R, Warner R, Levine SB. Letter to the editor. Reflections on hemophilia camp. Clinical Pediatrics 1991; 30(4):259-260

66) Successful Sexuality. Belonging/Hemophilia. (Caremark Therapeutic

Services), Autumn, 1991

67) Psychological intimacy. Journal of Sex & Marital Therapy 1991; 17(4):259-68

68) Male sexual problems and the general physician, Georgia State Medical Journal 1992; 81(5): 211-6

69) Althof SE, Turner LA, Levine SB, Bodner DB, Kursh E, Resnick MI. Through the eyes of women: The sexual and psychological responses of women to their partner's treatment with self-injection or vacuum constriction devices. Journal of Urology 1992; 147(4):1024-7

70) Curry SL, Levine SB, Jones PK, Kurit DM. Medical and Psychosocial predictors of sexual outcome among women with systemic lupus erythematosis. Arthritis Care and Research 1993; 6:23-30

71) Althof SE, Levine SB. Clinical approach to sexuality of patients with spinal cord injury. Urological Clinics of North America 1993; 20(3):527-34

72) Gender-disturbed males. Journal of Sex & Marital Therapy 19(2):131-141, 1993

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