NO. 22-1721

In The

United States Court Of Appeals

For The Fourth Circuit

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents; SAM SILVAINE; DANA CARAWAY,

Plaintiffs – Appellees,

v.

DALE FOLWELL, in his official capacity as State Treasurer of N.C.; DEE JONES, in her official capacity as executive Administrator of the N.C. State Health Plan for Teachers and State Employees,

Defendants – Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF NORTH CAROLINA AT GREENSBORO

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	Case No. 1:19-cv-00272-LCB-LPA

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION TO EXCLUDE EXPERT TESTIMONY OF DR. PAUL R. McHUGH

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Plaintiffs respectfully submit this memorandum of law in support of their motion to exclude the expert testimony of Dr. Paul R. McHugh.[1]

STATEMENT OF THE CASE AND FACTS

Plaintiffs are current or former participants in the North Carolina State Health Plan for Teachers and State Employees (the "Health Plan"). North Carolina provides health coverage to its employees and their dependents through the Health Plan. The Plan denies coverage for the gender-affirming care that transgender people require because it contains sweeping exclusions of such care but covers the same kinds of treatments for cisgender employees who require them for other reasons. Defendants thus deny equal treatment to Plaintiffs because they are transgender.

INTRODUCTION

For 50 years, Dr. Paul R. McHugh has opposed the provision of gender-affirming care for transgender patients, because in his view they have a "disorder of assumption." Dr. McHugh opposes this care despite not having any direct experience providing care to transgender individuals or having conducted any original research or study on these issues. In fact, his longstanding opposition has remained immovable – "flat-footed," in his words – notwithstanding any new research published in the past half century. Nonetheless, the Plan Defendants attempt to proffer Dr. McHugh as an expert.

[1] Unless otherwise specified, all exhibits cited herein are attached to the contemporaneously filed Declaration of Omar Gonzalez-Pagan.

But Dr. McHugh is unqualified to serve as an expert in this case and his opinions should be excluded as irrelevant and/or unreliable under Rule 702 and *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993), and its progeny. Dr. McHugh's views were formed 50 years ago despite his lack of direct experience and original study in these matters and have remained impervious to scientific development and scholarship since then. His opinions are also inadmissible under Rule 403 because any probative value they may have (and they have none) is substantially outweighed by the danger of unfair prejudice and confusion of the issues they would cause.

LEGAL STANDARD

Federal Rule of Evidence 702 places "a special gatekeeping obligation" on a trial court, *Nease v. Ford Motor Co.*, 848 F.3d 219, 230 (4th Cir. 2017), to ensure that an expert's testimony "both rests on a reliable foundation and is relevant to the task at hand." *Daubert*, 509 U.S. at 597; *see also Sardis v. Overhead Door Corp.*, 10 F.4th 268, 281 (4th Cir. 2021). And "the importance of the gatekeeping function cannot be overstated." *Sardis*, 10 F.4th at 283 (cleaned up).

"Where the admissibility of expert testimony is specifically questioned, Rule 702 and Daubert require that the district court make explicit findings, whether by written opinion or orally on the record, as to the challenged preconditions to admissibility." *Id.* "The proponent of the testimony must establish its admissibility by a preponderance of proof." *Mod. Auto. Network, LLC v. E. All. Ins. Co.*, 416 F.Supp.3d 529, 537 (M.D.N.C. 2019) (quotation omitted), *aff'd*, 842 F.App'x 847 (4th Cir. 2021).

First, the court must determine whether the proposed expert is even qualified to render the proffered opinion, which requires examining the expert's professional qualifications and "full range of experience and training." *Belk, Inc. v. Meyer Corp.*, U.S., 679 F.3d 146, 162 (4th Cir. 2012). If the purported expert is not qualified, the court should exclude the testimony. *See SMD Software, Inc. v. EMove, Inc.*, 945 F.Supp.2d 628, 639 (E.D.N.C. 2013).

Second, even if the expert is qualified, the court must consider the relevancy of the expert's testimony as it is "a precondition to admissibility." *Sardis*, 10 F.4th at 282. To be relevant, the testimony must have "a valid scientific connection to the pertinent inquiry." *Id.* at 281. "[I]f an opinion is not relevant to a fact at issue, *Daubert* requires that it be excluded." *Id.*

Third, the court must inquire if the opinion is based on a reliable foundation, focusing on "the principles and methodology" employed by the expert to assess whether it is "based on scientific, technical, or other specialized knowledge and not on belief or speculation." *Id.* at 281-82. In evaluating reliability, courts consider, among other things, whether: (1) the theory "can be and has been tested"; (2) has been "subjected to peer review and publication"; (3) "the known or potential rate of error"; and (4) "whether the technique is generally accepted in the scientific community." *Id.* at 281; *see also Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 149-150 (1999). These factors are "neither definitive, nor exhaustive." *Cooper v. Smith & Nephew, Inc.*, 259 F.3d 194, 199–200 (4th Cir. 2001) (citation omitted).

When an expert relies upon his experience and training, and not a specific methodology, the application of the *Daubert* factors is more limited. *See Freeman v. Case Corp.*, 118 F.3d 1011, 1016 n.6 (4th Cir. 1997). In such cases, courts consider: "1) how the expert's experience leads to the conclusion reached; 2) why that experience is a sufficient basis for the opinion; and 3) how that experience is reliably applied to the facts of the case." *SAS Inst., Inc. v. World Programming Ltd.*, 125 F.Supp.3d 579, 589 (E.D.N.C. 2015); *see also Nat'l Ass'n for Rational Sexual Offense Laws v. Stein*, No. 1:17CV53, 2021 WL 736375, at *3 (M.D.N.C. Feb. 25, 2021).

Finally, the Fourth Circuit has cautioned that although the trial court has "broad latitude" to determine reliability, it must still engage in the gatekeeping process and not simply "delegate the issue to the jury." *Sardis*, 10 F.4th at 281. Even rigorous cross-examination is not a substitute for the court's gatekeeping role. *See Nease v. Ford Motor Co.*, 848 F.3d 219, 231 (4th Cir. 2017).

ARGUMENT

I. Dr. McHugh is not qualified to offer an expert opinion in this case.

An expert witness must possess the requisite "knowledge, skill, experience, training, or education" that would assist the trier of fact. *Kopf v. Skyrm*, 993 F.2d 374, 377 (4th Cir. 1993); *Wright v. United States*, 280 F.Supp.2d 472, 478 (M.D.N.C. 2003). If not qualified, the expert's testimony is unreliable. *Reliastar Life Ins. Co. v. Laschkewitsch*, No. 5:13-CV-210-BO, 2014 WL 1430729, at *1 (E.D.N.C. Apr. 14, 2014).

However, "qualifications alone do not suffice." *Clark v. Takata Corp.*, 192 F.3d 750, 759 n.5 (7th Cir. 1999); *see also Patel ex rel. Patel v. Menard, Inc.*, No. 1:09-CV-0360-TWP-DML, 2011 WL 4738339, at *1 (S.D. Ind. Oct. 6, 2011). Even "[a] supremely qualified expert cannot waltz into the courtroom and render opinions unless those opinions are based upon some recognized scientific method and are reliable and relevant under … *Daubert*." *Clark*, 192 F.3d at 759 n.5. To the contrary, "an expert's qualifications must be within the same technical area as the subject matter of the expert's testimony; in other words, a person with expertise may only testify as to matters within that person's expertise." *Martinez v. Sakurai Graphic Sys. Corp.*, No. 04 C 1274, 2007 WL 2570362, at *2 (N.D. Ill. Aug. 30, 2007); *see also Lebron v. Sec. of Fla. Dept. of Children and Families*, 772 F.3d 1352, 1369 (11th Cir. 2014).

Despite his decades of experience in the field of psychiatry, Dr. McHugh is not qualified to render expert opinions on any of the issues at hand because he has no direct, particular, or specialized experience regarding gender dysphoria, its treatment, or transgender people more generally. Dr. McHugh's opinions are a perfect example of the circumstance where a party's proposed expert only provides "generalized knowledge" that risks creating more confusion rather than aiding a trier of fact. But, as we know, "[g]eneralized knowledge of a particular subject will not necessarily enable an expert to testify as to a specific subset of the general field of the expert's knowledge." *Martinez*, 2007 WL 2570362, at *2. "For example, no medical doctor is automatically an expert in every medical issue merely because he or she has graduated from medical school or has

achieved certification in a medical specialty." *O'Conner v. Commonwealth Edison Co.*, 807 F.Supp. 1376, 1390 (C.D. Ill. 1992), *aff'd*, 13 F.3d 1090 (7th Cir. 1994); *see also*, *e.g.*, *Hartke v. McKelway*, 526 F.Supp. 97, 100-101 (D.D.C. 1981). Such is the case here.

Dr. McHugh formed the opinions he espouses today nearly 50 years ago, without conducting any independent research at the time. Ex. A at 147:21-138:3. But those opinions are not based on any direct experience with transgender patients or people living with gender dysphoria, or any independent research that he has conducted he has conducted since then. The opposite. Dr. McHugh admits that he has not directly treated *any* transgender patients with gender dysphoria, Ex. A at 36:7-38:5, 39:1-10, 62:4-10, nor has he overseen any clinic providing hormonal or surgical care for transgender patients, *id.* at 58:17-59:5. He also has not conducted *any* original or peer-reviewed research about gender identity, transgender people, or gender dysphoria. Ex. A at 27:20-28:2, 30:7-31:9, 147:21-148:3; *see also United States v. Jacques*, 784 F.Supp.2d 59, 62 (D. Mass. 2011).

The extent of Dr. McHugh's direct, personal experience in his more than 50 years in the field of psychiatry is that he has briefly consulted, but not provided care, with 30-35 transgender persons or their families. Ex. A at 28:12-14, 30:3-6. Curiously, though, whenever he has referred one of those 30-35 persons or their families for actual care, Dr. McHugh has referred them to only one psychiatrist—Dr. Fred Berlin. *Id.* at 38:6-21. Dr. Berlin, however, works in Johns Hopkins's Sex and Gender Clinic, which partners with the Johns Hopkins Center for Transgender Health to provide gender-affirming care consistent with the standards of care set by the World Professional Association for

Transgender Health (WPATH), *id.* at 124:17-125:13; Ex. B at 261:2-262:6, and therefore provides care at odds with Dr. McHugh's outlier views.

And even though he purportedly calls for additional research on the effectiveness of gender-affirming treatment for gender dysphoria, it appears such calls are a pretense for Dr. McHugh's uninformed opposition to such care. Dr. McHugh has been aware of the provision of gender-affirming care since the 1970's, when he made up his mind to oppose this care but has yet to conduct a single study in the last 50 years. Ex. A at 155:6-10. As he testified, he joined Johns Hopkins with the "intention when [he] arrived in Baltimore in 1975 to help end" the provision of such care. *Id.* at 145:6-16.

Dr. McHugh has also not published any scientific, peer-reviewed literature on gender dysphoria or transgender people. Ex. A at 33:15-34:11. The one publication he has in a science journal that touches on this subject is not a scientific study but rather an opinion essay. *Id.* at 31:18-33:14; *see also* Ex. D.[2] But opinion pieces are not science. And a commentary piece from more than 25 years ago is not the type of creditable scientific literature that should inform an expert's opinions and testimony. More relevant, however, is whether Dr. McHugh's views have been peer-reviewed, vetted, and accepted in recent times. When asked if he had "sought to have his views regarding this matter, in the last few years, published in a peer-reviewed journal," Dr. McHugh testified he had asked the

[2] Commentary pieces in *Nature Medicine* are not necessarily peer reviewed. *See Content Types*, Nature Medicine, https://www.nature.com/nm/content (last visited Nov. 24, 2021).

New England Journal of Medicine if he could write something on these issues for them, but that the New England Journal of Medicine declined. Ex. B at 282:25-283:8.

Instead, Dr. McHugh bases his opinions solely on his review of literature and the few conversations he has had with people with whom he has provided limited consultations but not provided care. Ex. A at 28:3-11, 30:7-20.

Dr. McHugh testified: "I have not published an actual study. Right. I've reviewed studies, but I haven't made a study of my own, no." Ex. B. at 280:24-281:3. But the fact that Dr. McHugh has read about gender dysphoria and transgender people does not qualify him as an expert on these issues. "Expertise is not acquired through osmosis or accretion." *Veryzer v. Sec'y of Health & Hum. Servs.*, No. 06-0522V, 2010 WL 2507791, at *26 (Fed. Cl. June 15, 2010). That is precisely the sort of "generalized knowledge of a particular subject" that courts have rejected as a qualification under Rule 702. As with the disqualified expert in *Lebron* who "reached his opinion instead by relying on studies," it is simply not a sufficient qualification to serve as an expert witness. 772 F.3d at 1369.

The same holds true for the limited consultations he has had with people he has not provided any care. Dr. McHugh cannot speak of long-term effects of gender-confirming care when the few people he has consulted with received no care from him, let alone "long-term" care. Ex. A at 28:19-29:4, 36:21-37:9.

In sum, Dr. McHugh has no foundation of knowledge, skill, or experience necessary to serve as an expert on the diagnosis of gender dysphoria or the treatment paradigms for gender dysphoria. The fact that Dr. McHugh may be "an intelligent man," who is "well

read in the area," "has written a bit on the general topic," and "holds an opinion on the topic," "is not enough" to make him an expert on gender dysphoria and its treatment. *Jacques*, 784 F.Supp.2d at 62. Dr. McHugh's "degree of specialized knowledge is simply too thin to give his testimony the foundation needed to permit a [factfinder] to consider it." *Id.* Dr. McHugh is "not qualified by background, training, or expertise to opine" about any of the factual issues presented by this case, let alone the effects and propriety of a policy excluding coverage of medically necessary gender-confirming treatment for gender dysphoria. *Lebron*, 772 F.3d at 1369.

II. Dr. McHugh's opinions and testimony are not relevant to this case.

The "court must satisfy itself that the proffered testimony is relevant to the issue at hand, for that is a precondition to admissibility." *Sardis*, 10 F.4th at 282 (cleaned up). "[I]t is axiomatic that expert testimony which does not relate to any issue in the case is not relevant and non-helpful." *Knight v. Boehringer Ingelheim Pharms., Inc.*, 323 F.Supp.3d 837, 846 (S.D.W. Va. 2018) (cleaned up). In order to be relevant, an opinion needs to "fit" with the facts at issue. *Bourne v. E.I. DuPont de Nemours & Co.*, 85 F.App'x 964, 966 (4th Cir. 2004). "The test for relevance, or fit, considers whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute." *Viva Healthcare Packaging USA Inc. v. CTL Packaging USA Inc.*, 197 F.Supp.3d 837, 846 (W.D.N.C. 2016) (cleaned up).

Dr. McHugh's opinions are not relevant to the issues in this case as they will not help the "trier of fact to understand the evidence or to determine a fact in issue." *Nease*, 848 F.3d at 229. Simply put, his opinions do not "fit" the facts at issue.

A. Dr. McHugh's opinions about "desistance" are irrelevant.

Take for example Dr. McHugh's opinions about purported "desistance" rates as a reason to question the provision of gender-confirming care. Dr. McHugh builds his ultimate opinion that "transgender patients should [] be encouraged to align their identity and presentation with the sex they were determined at birth," Ex. A at 201:18-202:12, upon the premise that "the evidence right now is to say if somebody says … their sex of opinion and the sex of their body are discordant -- discordant, they change and become concordant in 80 to 90 percent of the cases if they're allowed to go through puberty." *Id.* at 197:15-21. But not only are such opinions based on faulty propositions, they simply do not fit within the facts of this case.

For example, Dr. McHugh's opinion is based on antiquated studies showing that a majority of prepubertal children diagnosed with *gender identity disorder*—an outmoded diagnosis *distinct from gender dysphoria* with different diagnostic criteria—desisted from their gender nonconformity or cross-gender behavior. But the desistance studies to which he refers speak only to prepubertal youth who were diagnosed with *gender identity disorder* under prior versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM"), and do not pertain to desistance in prepubertal youth diagnosed with *gender dysphoria* under the DSM-5. Ex. A at 196:12-20. A

distinction he does not understand (which further calls into question his purported expertise on the subject). *Id*. And in any event, the studies pertain to desistance among *prepubertal* children and not adolescents or adults. *Id.* at 194:3-11. But no hormonal or surgical care – i.e., the care at issue here – is recommended for or provided to *prepubertal* children, nor are any of the plaintiffs prepubertal children. Ex. B at 288:2-17.

Dr. McHugh's opinions regarding desistance are thus completely irrelevant.

B. Dr. McHugh's opinions regarding the validity and reliability of the DSM are irrelevant.

Dr. McHugh's opinions about the validity and reliability of the DSM, *see infra*, are also irrelevant. Dr. McHugh's opinions about the DSM are based on "a broader critique … in almost what its purpose is, that rather than serve as a guide to come up with a diagnosis based on observable phenomena or criteria, it should be more explanatory as to the nature and cause of a particular condition." Ex. A at 107:11-108:8. Dr. McHugh's critique *is not* based on the DSM's reliability to make diagnoses, i.e., to ascertain whether someone presenting with particular symptoms suffers from a particular condition. *Id.* at 99:3-100:16.

In any event, Dr. McHugh acknowledges that the World Health Organization's Internal Classification of Diseases (ICD) is a true classification system. Ex. A at 97:1-6. And the ICD defines gender incongruence as "a marked and persistent incongruence between the gender felt or experienced and the gender assigned at birth." *Id.* at 104:5-16; Ex. E.

C. Dr. McHugh's musings about the causes of gender dysphoria are irrelevant.

Dr. McHugh opines, without any evidence, that gender dysphoria *may be* caused by social contagion and social pressure. Ex. C at 13. While those hypotheses are completely unsupported, whether gender dysphoria is caused by social contagion or social pressure is irrelevant to the case at hand. It is undisputed that there are people that experience gender dysphoria, which necessitates medical treatment. Ex. A at 73:15-75:15, 203:14-204:14; *see also Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 594–95 (4th Cir. 2020).

* * *

The opinions expressed by Dr. McHugh are insufficiently tied to the facts of this case and should be excluded as irrelevant.

III. Dr. McHugh's opinions and testimony are unreliable.

An expert's testimony should only be admitted if it is sufficiently reliable. And "proffered evidence that has a greater potential to mislead than to enlighten should be excluded." *In re Lipitor (Atorvastatin Calcium) Mktg., Sales Pracs. & Prod. Liab. Litig. (No II) MDL 2502*, 892 F.3d 624, 632 (4th Cir. 2018). Here, Dr. McHugh's opinions fail all indicia of reliability. Dr. McHugh's proffered opinions are based on nothing more than rank speculation, "untested" theories, uncorroborated anecdotes, and assumptions that are obsolete, flawed, unethical, and expressed opinions based upon "unsettled science." What is more, some of his opinions are patently false.

A. Dr. McHugh's opinion encouraging reparative therapy is unreliable, widely rejected, unethical, and misleading.

The foundation of Dr. McHugh's opinions is that, according to him, transgender people are "disordered" because they suffer from a "disorder of assumption" or "overvalued idea." Ex. A at 129:5-12; Ex. B at 288:18-22. As such, Dr. McHugh's opinion is that transgender people with gender dysphoria be treated through therapy wherein they are led "to move from an idea that is unreal to the reality world that they need to live in and they should live in," by which he means that they should be coerced to live and identify according to "their natal sex." Ex. A at 204:20-206:5, 201:18-202:7. But such opinion is unreliable, widely rejected, and unethical.

Dr. McHugh cites to no study in support of this proposition, instead, "relying on, primarily, common sense." Ex. B at 305:17-21. In fact, from Dr. McHugh's point of view, it "is [his] opinion," and the burden of proof is on everyone else to change his opinion. *Id.* at 305:22-306:10. But that is not how it works in court, where a proposed expert's "*ipse dixit* … cannot satisfy Rule 702." *Sardis*, 10 F.4th at 289. Nor does Dr. McHugh's appeal to untestable "common sense" satisfy Rule 702's reliability requirement. *See Fedor v. Freightliner, Inc.*, 193 F.Supp.2d 820, 832 (E.D. Pa. 2002) ("Generalized common sense does not rise to the level of expert opinion solely because it is offered by someone with an academic pedigree.").

But "[f]or many years, mental health practitioners attempted to convert transgender people's gender identity to conform with their sex assigned at birth, which did not alleviate dysphoria, but rather caused shame and psychological pain." *Grimm*, 972 F.3d at 595. As

such, the American Psychological Association opposes gender identity change efforts because "scientific evidence and clinical experience indicate that [these efforts] put individuals at significant risk of harm" and "have not been shown to alleviate or resolve gender dysphoria." Ex. F; *see also* Ex. A at 210:19-213:21. So does the American Psychiatric Association. *Id.* at 206:6-20.

As a result, gender identity change efforts are considered to be unethical, and have been widely rejected by the medical and scientific community. Ex. A at 214:1-14; Ex. G at 12-16; *see also King v. Governor of the State of New Jersey*, 767 F.3d 216, 221–22 (3d Cir. 2014); *Pickup v. Brown*, 740 F.3d 1208, 1223–24 (9th Cir. 2014).

B. Dr. McHugh's views are at odds with the relevant scientific and medical communities.

General acceptance in the relevant scientific community is an important element to the reliability inquiry. *Nease*, 848 F.3d at 229. Not only is widespread acceptance an important factor in assessing the reliability of an expert's opinions, but the fact that a known theory "has been able to attract only minimal support within the community may properly be viewed with skepticism." *Daubert*, 509 U.S. at 594. Here, Dr. McHugh's opinions about the effectiveness and propriety of gender-affirming care are way outside the mainstream of medical and scientific opinion and have been explicitly rejected by the relevant scientific and medical communities.

Dr. McHugh opines that gender-affirming "treatments – hormones and surgery – for gender dysphoria and 'transitioning' remain unproven and have thus not been accepted by the relevant scientific communities." Ex. C at 14. Not true. It is the official, consensus,

evidence-based position of the National Academies of Science, Engineering, and Medicine that, "[a] major success of these guidelines has been identifying evidence and establishing expert consensus that gender-affirming care is medically necessary and, further, that withholding this care is not a neutral option." Ex. G at 12-10.[3] Indeed, "[a] number of professional medical organizations have joined WPATH in recognizing that gender affirming care is medically necessary for transgender people." *Id*. This includes, among others, the American Medical Association, American Psychiatric Association, American Psychological Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, the Endocrine Society, the Pediatric Endocrine Society, and Dr. McHugh's own employer, Johns Hopkins University. Ex. B at 247:22-263:14.

Binding and recent circuit precedent recognizes the provision of gender-confirming care, consistent with the WPATH Standards of Care, to "represent the consensus approach of the medical and mental health community," and to "have been recognized by various courts, including [the Fourth Circuit], as the authoritative standards of care." *Grimm*, 972 F.3d at 595. In fact, "[t]here are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups." *Id.* at 595-596.

[3] Exhibit G, a report of the National Academies, is self-authenticating as a publication issued by a public authority, Fed. R. Evid. 902(5), and is appropriate for judicial notice, *United States v. Doe*, 962 F.3d 139, 147 n.6 (4th Cir. 2020).

Just this year, another federal district court found as much when it enjoined Arkansas' state law seeking to ban gender-confirming treatment for minors. *See Brandt v. Rutledge*, No. 4:21-CV-00450-JM, 2021 WL 3292057 (E.D. Ark. Aug. 2, 2021). In doing so, the court explicitly found that: (a) "Gender-affirming treatment is *supported by medical evidence* that has been *subject to rigorous study*;" and (b) "*Every major expert medical association* recognizes that gender-affirming care for transgender minors may be *medically appropriate and necessary* to improve the physical and mental health of transgender people." *Id.* at *4 (emphasis added).

On the other hand, Dr. McHugh's view that affirming a transgender person's identity is "affirming the patient's misdirection," Ex. A at 64:19-65:6, has been soundly rejected by medical and scientific community.

Lastly, aside from the fact that his opinion is wildly at odds with that of the relevant medical and scientific communities, the fact that Dr. McHugh omitted key information from his report undermines his reliability and illustrates that his opinions are more likely to mislead than to enlighten. Dr. McHugh was aware that the positions taken by most major medical organizations and his own employer were contrary to his own but failed to disclose or account for that information in his report just because he disagreed with them. Ex. B at 257:6-17. While the factual basis of an expert opinion usually goes to credibility, "it is possible for an experts' omission of articles to render his or her opinion inadmissible on reliability grounds." *Huggins v. Stryker Corp.*, 932 F.Supp.2d 972, 994 (D. Minn. 2013). Such is the case here where Dr. McHugh omits key information, or worse,

misrepresents facts that if properly disclosed would contradict his opinions. In such circumstances, the "potential to mislead" rather "than to enlighten" is too great. *In re Lipitor*, 892 F.3d at 632.

C. Dr. McHugh's opinions are based on speculation and untested theories.

Dr. McHugh's opinions are based on speculation and untested theories; theories that neither he nor others have tested or studied. For example, several of Dr. McHugh's opinions are based on "unknown number[s]" of patients with gender dysphoria purportedly (a) suffering from other conditions distorting their judgment or (b) being "heavily influenced and/or manipulated by a source of social contagion." Ex. C at 13. But Dr. McHugh was unable to identify a single scientific, peer-reviewed source as to the former, Ex. B at 293:22-295:8, and only identified one source that proposed the latter merely as a hypothesis, *id.* at 298:15-300:5.[4] As such, "there is simply too great an analytical gap between the data and the opinion proffered." *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997).

"While hypothesis is essential in the scientific community because it leads to advances in science, speculation in the courtroom cannot aid the fact finder in making a determination." *Dunn v. Sandoz Pharms. Corp.*, 275 F.Supp.2d 672, 684 (M.D.N.C. 2003). Indeed, such "speculation is unreliable evidence and is inadmissible." *Id.*; *see also Sardis*, 10 F.4th at 291.

[4] The only study to have looked at this hypothesis found no support for the hypothesis. Ex. H.

In sum, Dr. McHugh's opinions based on "unsupported speculation" should be rejected. *Daubert* 509 U.S. at 589-590.

D. Dr. McHugh's opinions regarding care in other countries are unreliable.

In support for his opinions, Dr. McHugh refers to purported "national research reviews in England, Sweden, and Finland." Ex. C at 10. But it is hard to ascertain the reliability, if any, of these purported national reviews. For one, Dr. McHugh provides no citations to any these purported reviews in his report. For another, Dr. McHugh does not know if the "national reviews" in England and Finland were peer-reviewed or published in scientific journal. *See*, *e.g.*, Ex. B at 300:19-301:10 (England), 302:20-303:8 (Finland). He also confused a scientific study by some researchers in Sweden for a "national review," a distinction he acknowledged at his deposition. *Id.* at 301:12-20 (confusing the Dhejne, et al. 2011 study with Swedish national review).[5]

In addition, Dr. McHugh acknowledged he did not disclose that each of the countries to which he refers have nationalized healthcare systems that provide and cover gender-confirming medical treatment for adolescents and adults with gender dysphoria. *Id.* at 304:10-305:7.

[5] In any event, Dr. McHugh misrepresents the Dhejne, et al. study which only shows that post-operative transgender patients have higher rates of suicidality when compared to the *population at large*. Ex. A 157:10-160:16, 163:6-164:15; *see also* Doc. 181-1 (Ex. 25(a) at ¶ 83 (Ettner); Ex. 26(a) at ¶ 81 (Olson-Kennedy); Ex. 24(b) at ¶ 28 (Schechter Rebuttal)).

E. Dr. McHugh's opinions regarding the reliability of the DSM are unreliable and misleading.

Dr. McHugh criticizes the reliability and validity of the DSM to make diagnoses, which consequently fuels his opinions regarding gender dysphoria. But not only are these opinions irrelevant (see above), they are also unreliable.

Courts have routinely recognized the DSM as a reliable and widely accepted authority on mental disorder diagnoses. *See United States v. Wooden*, 693 F.3d 440, 452 n.4 (4th Cir. 2012) ("The DSM is widely recognized as the authoritative reference used in diagnosing mental disorders." (cleaned up)); *see also Acevedo Granados v. Garland*, 992 F.3d 755, 760 n.1 (9th Cir. 2021); *Kim v. Hartford Life Ins. Co.*, 748 F.App'x 371, 374 (2d Cir. 2018); *Rasho v. Elyea*, 856 F.3d 469, 472 (7th Cir. 2017); *Young v. Murphy*, 615 F.3d 59, 61 (1st Cir. 2010); *Vanieken-Ryals v. Off. of Pers. Mgmt.*, 508 F.3d 1034, 1037 (Fed. Cir. 2007).

In addition, Dr. McHugh criticizes the DSM as "not based on evidence-seeking scientific methodologies," Ex. A at 105:2-6, even though he acknowledges that the revision of the DSM involves research evaluation, publication of whitepapers, peer-reviewed articles, and scientific conferences, *id.* at 105:16-106:18, something he did not disclose. Yet, at his deposition, Dr. McHugh acknowledged the "DSM does use scientific information to encourage its own reliability studies." *Id.* at 107:3-5.

Dr. McHugh refers to the decision of the National Institute of Mental Health (NIMH) to "reorient[] its research away from DSM categories" as support for his view of the DSM as "insufficiently reliable." Ex. C at 8. However, Dr. McHugh failed to disclose

that this was done as part of the NIMH's Research Domain Criteria project's "long-term goal to understand mental illness as disorders of brain structure and function," and that the NIMH considers the DSM, along with the ICD, to "represent[] the best information currently available for clinical diagnosis of mental disorders" and "that the DSM is the key resource for delivering the best available care" as well as "the main contemporary consensus standard for how mental disorders are diagnosed and treated." Ex. A at 116:10-122:11. The fact that Dr. McHugh misrepresented or omitted such information central to his opinions calls into question the reliability of his opinions.

Lastly, Dr. McHugh has authored and advocated for an alternative to the DSM since the 1980's, but as he admits, his alternative *is not* widely accepted by the relevant scientific and medical community. *Id.* at 108:9-110:14. And the fact that a known theory "has been able to attract only minimal support within the community may properly be viewed with skepticism." *Daubert*, 509 U.S. at 594.

F. Dr. McHugh's opinions rely on his own unreliable and non-scientific publications.

In his report, Dr. McHugh primarily relies on his own non-scientific, non-peer-reviewed publications as support for his own opinions. *See generally* Ex. C. But such publications lack any indicia of reliability. Really, they are all just opinion articles by Dr. McHugh, not actual studies. Ex. B at 280:24-281:3.

Take for example Dr. McHugh's two publications in *The New Atlantis*. *The New Atlantis* is neither a peer-reviewed nor a scientific publication, but rather "an ordinary journal for the public." Ex. B at 264:1-19. The same holds true for his other publications

on this area. *Id.* at 276:19-277:19, 279:20-280:7, 280:15-23; Ex. A at 21:17-22:4. Indeed, Dr. McHugh acknowledges these are all just articles of opinion, "as you might find in 'The Atlantic' or in 'The New Republic' or in 'The New Yorker.'" Ex. B at 266:3-5, 277:16-19.

As such, as a court that reviewed Dr. McHugh's "Sexuality and Gender" article noted, they do not carry "any … indicia of reliability." *Evancho v. Pine-Richland Sch. Dist.*, 237 F.Supp.3d 267, 278 n.12 (W.D. Pa. 2017). To the contrary, Dr. McHugh's publications have been publicly denounced by hundreds of scientists and medical professionals, which Dr. McHugh acknowledges are "part of the relevant scientific community," as not representing the "prevailing expert consensus opinion about sexual orientation or gender identity related research or clinical care." Ex. I; Ex. B. at 266:21-267:22.

Similarly, colleagues at Johns Hopkins have publicly denounced Dr. McHugh's publications as "mischaracteriz[ing] the current state of the science on sexuality and gender." *Id.* at 268:9-269:15; Ex. J. So did Dr. Dean Hamer, a renowned geneticist who Dr. McHugh describes as a "distinguished person" and "certainly relevant" part of the scientific community. Ex. B at 269:20-270:8. Indeed, Dr. Hamer has described the opinions expressed by Dr. McHugh in his non-scientific opinion pieces as "pure balderdash" that engage in "data cherry-picking" and "jump to [] conclusion[s], with no supporting evidence or calculations whatsoever," all for the "not-too-subtle implication … that LGBT people are intrinsically defective, and that no amount of legal or societal

acceptance will ever fix them." Dean Hamer, *New 'Scientific' Study on Sexuality, Gender Is Neither New nor Scientific*, The Advocate (Aug. 29, 2016, 2:21 PM), https://bit.ly/3xlpT2x.

In sum, Dr. McHugh's opinions should be excluded because they mostly rely on his own non-scientific opinion pieces that are themselves unreliable and have been resoundingly denounced by scientific community as misleading, at best.

G. Dr. McHugh's extreme opinions are unreliable because they are tainted with bias and prejudice.

Dr. McHugh's opinions are unreliable because they are tainted by bias and prejudice. Even Dr. McHugh's own co-authors, like Dr. Lawrence Mayer, have described his views regarding transgender people as "extreme" and "mean-spirited." Ex. B at 274:4-19. Dr. Mayer has described Dr. McHugh's statements regarding LGBTQ people as "anti-gay, anti-transgender." *Id.*

But one need not just rely on the views of Dr. McHugh's colleagues. One need only look at Dr. McHugh's writings and testimony to see that it is permeated with bias and prejudice. Take the following statements by Dr. McHugh:

- Stating that transgender people "are disordered" and "suffer from an overvalued idea," Ex. B at 288:18-21, 297:5-6;
- Describing transgender women as "caricatures of women," Ex. A at 143:3-14; Ex. B at 278:1:22;
- Referring to transgender people as "gender pretenders," Ex. B at 274:4-19, 276:1-14;

- Asserting that transgender people "have a disorder of assumption," Ex. A at 129:10-12;
- Declaring that "conditioning children into believing that a lifetime of impersonating someone of the opposite sex achievable only from chemical and surgical interventions is a form of child abuse," Ex. B. at 286:9-14; and
- Speaking of gender-affirming treatment as resulting in the "ghastliness of the mutilated body," Ex. A at 149:15-16.

Such rhetoric on its own illustrates how Dr. McHugh's opinions, which have been ossified since the 1970's, are so permeated by negative attitudes at best, and bias and prejudice at worst, as to render them completely unreliable. They also illustrate how Dr. McHugh's opinions have "a greater potential to mislead than to enlighten" and thus "should be excluded." *In re Lipitor*, 892 F.3d at 632. Indeed, Dr. McHugh testified that he is "quite flat-footed about this." Ex. B at 287:17-18.

And though Dr. McHugh's opinions illustrate bias regardless of motivation, it is also relevant that most of his publications on these issues are in religiously affiliated publications. For example, *The New Atlantis* was published by the Ethics and Public Policy Center, which represents itself as an "institute dedicated to applying the Judeo-Christian moral tradition to critical issues of public policy," which Dr. McHugh knew. Ex. B at 264:20-265:11. And Dr. McHugh's article "Surgical Sex" was published in *First Things*, a publication of the Institute on Religion and Public Life, *id.* at 276:19-277:9, and which he began by making reference to the "Serenity Prayer." *Id.* at 278:23-279:1.

It thus appears that Dr. McHugh's opinions are colored by his own private moral and religious beliefs, which is "critical information," the Court should consider as it "appropriately draw inferences about [Dr. McHugh's] reliability." *State v. Heinz*, 485 A.2d 1321, 1328 (Conn. App. 1984). To be clear, Dr. McHugh is entitled to hold his own private views, and Plaintiffs do not seek to impugn or malign them. However, to the extent Dr. McHugh's personal views have influenced his purported expert opinions—indeed, they appear to be a motivating factor—that is something the Court must be aware of and should consider as it assesses the reliability of his testimony.

Dr. McHugh's opinions should be excluded based on his extreme and negative rhetoric towards transgender people alone, which renders his opinions as unreliable.

* * *

In sum, Dr. McHugh's opinions fail to meet the most basic indicia of reliability and his opinions and testimony should be excluded as unreliable.

IV. Dr. McHugh's opinions lack probative value and are therefore inadmissible under Rule 403.

Finally, the Court should exclude Dr. McHugh's opinions because their introduction will result in unfair prejudice, confusion of the issues, or in misleading testimony. Fed. R. Evid. 403. Dr. McHugh offers no opinions relevant to the issues in this case, and, in any event, the opinions he offers are unfounded, speculative, and unreliable. The testimony would also result in prejudice, as the testimony seeks to sow confusion about the propriety of gender-confirming care based on speculation, irrelevant, misleading, or biased opinions.

CONCLUSION

For the foregoing reasons, the Court should exclude Dr. McHugh's report, opinions, and testimony in full.

Dated this 2nd day of February, 2022.

Respectfully submitted,

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* Appearing by special appearance pursuant to L.R. 83.1(d).

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief is in compliance with Local Rule 7.3(d)(1) because the body of this brief, including headings and footnotes, does not exceed 6,250 words as indicated by Microsoft Word, the program used to prepare this document.

Dated: February 2, 2022

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CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: February 2, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	Case No. 1:19-cv-00272-LCB-LPA

DECLARATION OF OMAR GONZALEZ-PAGAN

Pursuant to 28 U.S.C.§ 1746, I, Omar Gonzalez-Pagan, do hereby declare as follows:

1. I am over 18 years of age.

2. I am a Senior Attorney at Lambda Legal Defense and Education Fund, Inc. and serve as counsel of record for the plaintiffs in the above-captioned matter.

3. I have personal knowledge of the stated herein, except those stated on information and belief, and if called upon, could and would testify competently to them.

4. I submit this declaration in support of Plaintiffs' Motion to Exclude Expert Testimony of Dr. Paul R. McHugh.

5. Attached as **Exhibit A** is a true and correct copy of excerpts of the transcript of first day of the deposition of Dr. Paul R. McHugh on September 8, 2021 taken in relation to the above-captioned matter.

6. Attached as **Exhibit B** is a true and correct copy of excerpts of the transcript of second day of the deposition of Dr. Paul R. McHugh on October 29, 2021 taken in relation to the above-captioned matter.

7. Attached as **Exhibit C** is a true and correct copy of the expert witness report of Dr. Paul R. McHugh, M.D. (including a copy of his curriculum vitae) in the above-captioned matter, which is dated May 1, 2021, was served upon plaintiffs on May 1, 2021, and was entered as Exhibit 2 to Dr. McHugh's deposition in this matter.

8. Attached as **Exhibit D** is a true and correct copy of the essay by Dr. McHugh "Witches, multiple personalities, and other psychiatric artifacts," authored by Dr. McHugh and published in the journal *Nature Medicine* in February 1995.

9. Attached as **Exhibit E** is a true and correct copy of the entry for "Gender Incongruence" in the International Classification of Diseases, 11th Revision, published by the World Health Organization and last revised in May 2021. It can be publicly accessed at https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/411470068.

10. Attached as **Exhibit F** is a true and correct copy of the "APA Resolution on Gender Identity Change Efforts" published by the American Psychological Association in February 2021, and which was entered as Exhibit 12 to Dr. McHugh's deposition in this matter on September 29, 2021.

11. Attached as **Exhibit G** is a true and correct copy of excerpts of *Understanding the Well-Being of LGBTQI+ Populations*, a Consensus Study Report of the

National Academies of Sciences, Engineering, and Medicine published in 2020, and which was entered as Exhibit 15 to Dr. McHugh's deposition in this matter.

12. Attached as **Exhibit H** is a true and correct copy of the journal pre-proof of the scientific, peer-reviewed article "Do Clinical Data From Transgender Adolescents Support the Phenomenon of 'Rapid-Onset Gender Dysphoria'?" authored by Greta R. Bauer, PhD, MPH, Margaret L. Lawson, MD, MSc, FRCPC, and Daniel L. Metzger, MD, FAAP, FRCPC, and published in the scientific, peer-reviewed journal *The Journal of Pediatrics* on November 15, 2021.

13. Attached as **Exhibit I** is a true and correct copy of a March 22, 2017 public letter by 566 researchers and clinicians with expertise in gender and sexuality criticizing Dr. McHugh's "Sexuality and Gender" article, which was entered as Exhibit 19 to Dr. McHugh's deposition in this matter.

14. Attached as **Exhibit J** is a true and correct copy of the opinion article "Hopkins faculty disavow 'troubling' report on gender sexuality" authored by Dr. Chris Beyrer, Dr. Robert W. Plum, and Prof. Tonia C. Poteat and published in *The Baltimore Sun* on September 28, 2016, which was entered as Exhibit 20 to Dr. McHugh's deposition in this matter.

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

Dated this 2nd day of February, 2022.

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan

EXHIBIT A

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF NORTH CAROLINA

* * * * *

MAXWELL KADEL, et. al., *
Plaintiffs * Case No.:
vs. * 1:19-CV-00272-LCB-LPA
DALE FOLWELL, et.al., *
Defendants *

* * * * *

Remote videotaped deposition of PAUL McHUGH, M.D., was taken on Wednesday, September 8, 2021, commencing at 9:40 a.m., before Allison L. Shearer, RPR, a Notary Public.

Reported By: Allison L. Shearer, RPR

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EXAMINATION INDEX

EXHIBIT INDEX

EXHIBIT INDEX (Continued)

NOTE: Exhibits maintained in Exhibit Share.

Q. Have there been any updates to your CV since you submitted your report?

A. Only my recent publication in Commentary that was published in this -- the most recent issue of Commentary.

Q. And was --

A. You know, that's in my CV.

Q. Did this publication pertain to gender identity?

A. It did, yes.

Q. What's the name of the publication?

A. Oh, dear. It's -- let me -- just a second. I've got the magazine lying over here. It just -- it's not that I carried it with me. I just happen to have it in -- lying here. I'll get you the actual title.

It's entitled Uninformed Consent: The Transgender Crisis and it's written by me and Gerard Bradley, the Professor of Law at Notre Dame. And it's in the September issue of Commentary.

Q. And is Commentary a peer-reviewed

journal?

A. No.

Q. Is it a scientific journal?

A. No, it's a -- it's a journal of opinion.

Q. Thank you, Doctor. I know you have a long and sorted career so I -- I'm just going to try to go for some highlights today.

A. Nothing like living a long time; the curriculum vitae.

Q. Well, I can only hope to live this long so I appreciate it.

A. Yes.

Q. Where did you go to college?

A. I went to Harvard College.

Q. And when did you graduate?

A. 1952.

Q. And did you obtain a degree?

A. I did. I got a Bachelor's Degree from Harvard College, yes.

Q. And the Bachelor's Degree was in what?

A. It was in biology.

A. A what?

Q. Literature review. A new publication that is based on existing research out there, not --

A. Okay.

Q. Are you okay with my definitions for purposes of today?

A. I'm sure we can work with them and work to make each other clear, yes. You might have to help me from time to time, but I'm -- I'm very happy with those distinctions, yes.

Q. Understood. Thank you. You previously mentioned that you were an investigator, right?

A. Yes.

Q. As I understand it, you have conducted primary research into particular phenomena?

A. Yes, I've -- I've conducted basic physiological research, as well as applied research. Yes.

Q. Have you performed any primary research regarding gender dysphoria?

A. No, I -- I can't say that I've done -- done primary research.

Q. Has your study of the -- of gender dysphoria been limited to review of existing literature and studies?

A. Well, it's also been meeting patients and talking with patients. It's a bit on personal experience. It's a review of what's available and personal experience with patients that come to Johns Hopkins and have other reasons for consulting me.

Q. Okay. With about how many transgender patients have you worked with over your career?

A. I suppose 30 or 35.

Q. When was the last time you worked with a transgender patient?

A. Yes. Oh, probably a few months ago; talked with one. Mm-hmm.

Q. So one of your two to three current patients is a transgender person?

A. No, it's -- it's not. I don't -- I don't

care for them in long-term. They or their families call me and ask me for -- sometimes to see the patient and sometimes to advise them about other representations for their treatment.

And I will talk with them and give them my opinion about their situation and what seems to me to be the best use of the available treatments that are accessible to them. Yeah.

Q. Understood. When these patients and/or their families come to you, have any of these patients been minors?

A. Yes, most of them are minors that come to see me.

Q. How about -- let me go back. You mentioned previously that you've worked with 30 to 35 trans patients. Does this include these consultations?

A. These kinds of consultations, yes. Yeah.

Q. About how many of the 30 to 35 patients that you've worked with that were transgender have been minors?

A. Well, I'd say about 80 percent of them; 20 percent have been adults.

Q. And to clarify, you have not provided them with long-term care. You have provided a consultation for specific questions that they had?

A. That's right. Mm-hmm.

Q. Let's go back. Have you performed any primary research relating to transgender people?

A. Again, as I say, I'm not quite sure what you mean, but I have not -- importantly, what I have not done is made a -- a collection of my experiences with patients and pulled them together into a -- into a particular article or things of that sort.

I've used more secondary information that I've acquired by seeing what's being asked for the patients and what's in the literature. Yeah.

So I suppose I have not actually produced primary research and if I had, I would have, of course, published and we could have pointed to it.

Q. Okay. Thank you. And that's what I'm

getting at. So I -- I -- we don't need to make this overly difficult, right. So just so we understand each other, that's -- that's what I'm getting at, right.

I'm asking whether you have defined and conducted a study, whether clinical, observational, longitudinal, resectional, having to do with gender dysphoria or transgender people?

A. No. No, Mr. Gonzalez, I did not.

Q. Okay. Thank you. I have your CV in front of me. There are a ton of publications and -- over a long career.

A. Yeah.

Q. I understand that there are some of these publications that are peer-reviewed publications; is that right?

A. Yes. Yes, many of them. Yes.

Q. Are any of your peer-reviewed publications regarding gender dysphoria?

A. No -- well, yes. Yes, one of them. One of them in the -- in Nature Medicine entitled

Witches, Multiple Personalities, and other things. Yes, that's a peer-reviewed journal.

And in it I lay out my opinions about the transgender phenomenon. You'll find it in the Nature Medicine article.

Q. Do you recall about when this article was published?

A. In the 1990s somewhere. I've had a long experience discussing these matters and I was talking about it back in the '90s. You'll find it in my CV, if you look.

Q. Oh, no, I am looking. So just --

A. I'm --

Q. I was just going through it. Just going through it just to kind of --

A. --

Q. -- to make sure we --

A. --

Q. -- we're talking about the same... So this is in Nature Medicine, right?

A. Right. That's right.

Q. Is this the article, Witches, Multiple Personalities, and Other Psychiatric Artifacts?

A. That's right.

Q. Okay.

A. That's the one.

Q. And is this article based on primary research?

A. No, it's involved in a -- a consideration of what was the themes at that time about the transgender/transsexual treatments and the involvement at Johns Hopkins with it. It was a -- it was a commentary on the state of the literature then that was published in this peer-reviewed journal.

Q. Thank you. Aside from the article in Nature Medicine in 1995, do you have any other peer-reviewed publications regarding gender dysphoria?

A. No, I don't.

Q. Aside from the article --

A. I just have my opinion really from the

one that I expressed in that article. I beg your pardon. I'm sorry, sir. I interrupted you.

Q. No. No. It's no problem. Aside from the article in Nature Medicine in 1995, do you have any peer-reviewed publications relating to transgender people?

A. No.

Q. And aside from the article in Nature Medicine in 1995, do you have any peer-reviewed publications relating to gender identity?

A. No. No, sir.

Q. You also have a number of non-peer reviewed publications, right?

A. Yes.

Q. Are any of your non-peer reviewed publications regarding gender dysphoria?

A. Yes, some of them are. Yes.

Q. Which are those publications?

A. Which are they?

Q. Yeah.

A. Oh, good grief. There are -- there are

that is my first venture into this area. Yeah.

Q. So your first venture into publishing in this area was with Psychiatric Misadventures?

A. That's right.

Q. That was back in 1992?

A. That's right.

Q. All right. Have you ever diagnosed a person with gender dysphoria?

A. Yes.

Q. How many times?

A. Oh, as I said, most -- my 30 patients, 35 patients. I suppose most of them had gender dysphoria. So I suppose I thought they were all involved with it in some way or another. You know, they varied in intensity. Some of them were not. Some of the adults didn't have dysphoria and -- and were just looking to me to ask what I thought the outcome might be if they proceeded with their transsexual behavior and sought hormonal and surgical treatment.

Q. And when you met with these patients, you

were not seeing them long-term we've established, right?

A. That was right. I wasn't seeing them long-term.

Q. So were you providing them with care for their gender dysphoria?

A. I was providing -- providing them with advice about what I thought would do the best for them.

Q. Okay. And as I understand a little bit of the conversation, you think some of them had and some of them hadn't had gender dysphoria, but did you ever formally diagnose any of these patients?

A. By formally diagnosing that I wrote -- I wrote the patient up in some kind of way for the records in the hospital, no. I only saw them, advised them, and wrote about my advice to them.

Q. Were your consultations with these patients like one-offs or did it involve multiple visits?

A. Well, several of them involved several

visits. Not -- I wouldn't say multiple as though it was ongoing caregiving, but sometimes they had questions and sometimes the people I referred them to had questions and we talked back and forth a couple of times, yes.

Q. When you -- when you were presented with any of these patients, did you ever refer them to a provider that would provide gender-affirming care?

A. I -- I referred them sometimes. A couple of them I referred to somebody who could -- who I thought was equipped to offer them treatment, but not gender -- not necessarily gender-affirming, although they might when they -- when they reviewed the patient themselves come to that conclusion.

I referred them to particular -- a couple of them to Dr. Fred Berlin here at -- at Johns Hopkins who was a student of sexual behavior and offered them treatment.

Q. To whom besides Dr. Berlin did you refer patients to?

A. It was only Dr. Berlin.

Q. Is it fair to say that you're not -- have not provided care to a transgender patient diagnosed with gender dysphoria?

A. It's fair to say that I have not provided long-term care, no. That's correct. Mm-hmm.

Q. Is it fair to say that you have not provided care -- long-term care to a transgender patient diagnosed with gender identity disorder?

A. That's fair to say, at least personally. You have to remember, I was overseeing a -- for a while -- a sexual behavior unit in which care was being offered to these patients and my responsibility was to oversee that and recognize and advise as to the direction it was going in, but that experience was early in the 1970s.

Q. And this is in your capacity as psychiatrist-in-chief --

A. That's right.

Q. -- at Johns Hopkins --

A. That's right, yes.

Q. -- Hospital? And your tenure as

Q. Have you overseen any clinic providing gender-affirming care between 1979 to today?

MR. KNEPPER: Objection; form.

THE WITNESS: As I -- as I say, I don't like this term gender-affirming care. I have overseen clinics, that clinic in particular and it's later development in the offering of other forms of treatment other than physical forms of treatment --

BY MR. GONZALEZ-PAGAN:

Q. Right.

A. -- for the transgendered and transsexual patients. Yes.

Q. Okay.

A. But that was -- that was -- that was it, sir. Yeah.

Q. All right. Just because there was an objection and just to clarify the record, in your capacity as a physician at Johns Hopkins, have you overseen or directed any clinic providing medical and surgical interventions for the treatment of

gender dysphoria since 1979?

A. No. I --

Q. Thank you.

A. -- think the fair answer to that is no. I think that's fair.

Q. You mentioned that your conclusion that there's a uni-directed Transgender Treatment Industry was based on your clinical observations -- well, was based on your conversations with 30 to 35 transgender patients, your experience with the sexual behaviors clinic at Johns Hopkins from 1975 to 1979, and what you've heard from other people; is that right?

A. Once again, you stop at 1979 as though I was stopped from that point on seeing any kinds of an understanding from other kinds of patients that came then, even though we were not offering these so-called treatments, that we didn't oversee and observe what the treatments had been that brought them to us and for which we were offering an alternative. No. So --

conferences that were -- out of conferences that would be taking place around the Sexual Behavior Clinic.

Q. Okay. But not patients that -- let me rephrase that. Your experience with regards to patients diagnosed with gender identity disorder or gender dysphoria is limited to this 30 to 35 patients; is that right? Direct experience.

A. No. No. My -- my direct personal experience out of the care would be that, yes.

Q. Right.

A. But my oversight gave me consultation and responsibility for hundreds of patients that were flowing through that clinic both before we stopped offering the surgical treatment and afterwards I would say.

Q. These are patients that were being seen by other physicians that were under your purview?

A. That's right.

Q. Okay. Is the term Transgender Treatment Industry a term of art?

A. That's okay.

Q. -- have practiced in this field for a while. So it was new.

A. That's -- that's wonderful, Mr. Gonzalez. I appreciate your pointing this out. Mm-hmm.

Q. So I will ask this: Is it a term that you commonly use?

MR. KNEPPER: Objection.

THE WITNESS: No. I'm using it more and more frequently now and as I'm more and more impressed by the single-mindedness of the treatments being offered, I -- for example, I even think this idea, the very concept of affirming, gender-affirming treatment, is an expression of that industrial movement. I -- I don't think there's anything affirming about any of this.

BY MR. GONZALEZ-PAGAN:

Q. Well, isn't the idea that you are affirming the person's identity?

A. No, it's affirming the patient's

misdirection and therefore affirming isn't the correct word I don't think, but -- but, you know, we could -- we could talk about that just as it's -- it has become a -- a term of art within the industry, but it -- it's -- it's an easily challengeable word.

Q. When did you first hear the term Transgender Treatment Industry?

A. Oh, dear. As I say, I --

MR. KNEPPER: Objection; asked and answered.

THE WITNESS: That's right. I've got no idea when -- when I heard it or if I heard it from somebody else or I thought it up myself in the process of watching what was happening.

I was trying to characterize in words what I thought was happening and the huge increase in patients that were making the claims that they were of the opposite sex, just the building up of some 4,000 percent more women, young women, reporting this. It was just --

overreliance on the DSM?

A. Do I opine? I think that part of the problem is DSM for all of the -- our woes in psychiatry right at the moment and many of the arguments we get into relate to the fact that the DSM is the so-called bible of our discipline rather than a true classification of -- of mental disorders like we have a true classification of medical disorders.

Q. Sure. And to clarify, the DSM is the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; is that right?

A. Yes, it is. Yes.

Q. Okay. Let me ask you: Do you -- is gender dysphoria a very real condition? Well, let me scratch that. Is gender dysphoria a real condition?

A. Well, it's certainly a feeling that patients report. So this concept --

Q. Well --

A. This concept of -- look, this is just what I do every day, Mr. Gonzalez. This concept of a real thing versus a feeling or an attitude or an assumption are all important things to distinguish because those things differ in relationship to their generation.

Something that is a condition like heart failure or pneumonia can be attributed and called a condition because it has a common generation and a -- a common outline.

Gender dysphoria like many other sort of senses and feelings can come from all kinds of different directions and therefore it's best thought of as a state of mind. Let's put it that way. It's a state of mind.

Q. Well, how would you define gender dysphoria?

A. Well, as I say, it's a state of mind in which a person has come to feel somehow from -- for reasons that we don't quite understand that he or she belongs to the opposite sex and is discomforted

by the fact that his body and -- and the world around him does not agree with that.

Q. Would you agree that there are people that experience distress due to the misalignment of their perceived gender identity and their sex assigned at birth?

A. All of those things are -- are terms that I would debate with you, each one of them alone. You don't assign a sex at birth. You discover sex -- sex at birth.

There are plenty of people though in the world who right now for a variety of reasons, many of which are still to be discovered, find themselves arguing that they don't feel comfortable in their body, their sexual body.

Q. How is the sex of a child determined at birth?

A. Well, it's usually very -- about 99 percent of them are determined by the parents of the body and it turns out to be quite correct in relationship, both to the chromosomal --

Q. Would you then -- would you consider the ICD, the International Classification of Diseases, to be a classification?

A. Yes, that is and when you compare the two, you can see the difference. You have to be a physician to read ICD and understand it.

You have -- you don't have to be a physician -- as you know, anybody can read DSM and it's even said that -- that authors use DSM to characterize some of the characters they're going to put in their fiction.

Q. Okay. Would you agree that the DSM, however, does not prescribe treatment?

A. Yes. Yes. Yes. I -- I suppose it doesn't.

Q. You describe the DSM as "essentially a dictionary based on consensus-seeking voting methodologies rather than evidence-based" -- apologies -- "rather than evidence-seeking scientific methodologies."

A. Yes. Yes.

Q. -- view of the DSM.

A. Okay.

Q. Would you say that the DSM is a reliable tool for the diagnosis of particular conditions, but that it does not --

A. It's --

Q. -- explain the causes of said condition?

A. I'm -- I'm afraid you're using the term reliable in a way that -- that you and I ought to be clear about. It is reliable in the sense that other people can agree that that term applies here, but it is not valid in the sense of understanding what the condition really is between the people, okay.

So often the word reliable as used by other people outside of science is used as a way of saying well, if this is a reliable diagnosis, it must be a correct diagnosis or an understanding diagnosis. I want to make a point that this is only to permit people to use the same words for patients that look alike.

Q. Understood. So in diagnosing patients, without delving into the treatment and/or causes for said patient's condition, does the DSM serve to identify a diagnosis?

MR. KNEPPER: Objection; form.

BY MR. GONZALEZ-PAGAN:

Q. I guess what I'm trying to get at here is: What would you use to diagnose a patient? Like isn't it -- isn't the purpose of the DSM to come up with some common language for mental health practitioners?

A. The purpose of DSM is to make sure that people are referring to patients that look alike, but it is not its purpose to presume that those things that look alike have the same sources and the same natures, okay?

Q. Understood.

A. I mean, I wrote an -- an article in the New England Journal with Dr. Slavney that, you know, made reference to it before and what I was -- what I wanted to use for the title is What is

but if you look at it in general medical terms, the ICD in cardiology and all those, that is a real classification and you have to be a doctor to really understand it.

Q. Okay. The ICD defines gender incongruence as "a marked and persistent incongruence between the gender felt or experienced and the gender assigned at birth" Are you aware of that?

A. I'm not, but it doesn't surprise me.

Q. Okay.

A. It uses all the usual words, including the word gender.

Q. It also uses assigned at birth.

A. Yeah. Exactly. It -- it says that, too. It -- it will change.

Q. Okay. Going back to -- to the statement that you made in your report --

MR. GONZALEZ-PAGAN: And we can -- we can take off -- take it off the screen.

THE WITNESS: Okay.

BY MR. GONZALEZ-PAGAN:

Q. You indicated that the DSM is not based on evidence-seeking scientific methodologies; is that right?

A. No, it's -- it's based on appearances. It says so.

Q. Okay. Are you aware that the revision of the DSM involves a multi-year process?

A. No, the DSM's fifth edition has tried to be -- to modify it just as they did in DSM-4, but -- DSM-3, but it still uses the same methodology, the same -- same method and with the assumption that you had to find reliability and then through reliability you might get to validity and intelligibility didn't matter.

Q. Okay. Are you aware that the revision of the DSM involves research evaluation, publication of whitepapers, peer-reviewed articles, and scientific conferences?

A. Yes, I am and I'm also aware that DSM has decided that it still would use the original

approach that -- that it took, that the sciences and the things of that sort were -- that they'd employed were methods that employed ways of demonstrating that they could still find reliability in the sense of consistency in diagnosis.

Nothing -- nothing radically changed between DSM-3 and DSM-5 in relationship to the method that was being employed.

Q. Are you aware that there were -- revision of the DSM involves the establishment of task force and workgroups that review scientific literature?

A. Of course I am, yes.

Q. Are you aware that the revision of the DSM involves the establishment of scientific review committee that evaluated and provided guidance on the strength of evidence of any proposed changes?

A. Yes.

Q. Would it be fair to say then that the development of the DSM does involve the evaluation of scientific information and literature?

A. Well, that word scientific is being used -- you're using it in a -- in a very broad sense. It is useful and -- and DSM does use scientific information to encourage its own reliability studies. That's scientific, but it's not necessarily related to validity.

And nothing has been done in relationship to validating the distinctions of any of these conditions in relationship to their sources, their generative sources.

Q. If I'm understanding correctly where you're coming from here, and just correct me if I'm wrong, is a broader critique of the DSM in almost what its purpose is, that rather than serve as a guide to come up with a diagnosis based on observable phenomena or criteria, it should be more explanatory as to the nature and cause of a particular condition?

A. Yes, a real classification as in general medicine would. And psychiatry should be working towards a classification that rests itself in the

distinctions amongst conditions related to their generation.

This is -- this is a very simple scientific concept that extends far back into scientific studies, but the field guide step, which is the step that DSM is, is considered only a step on the pathway to an ultimate coherent classification or a method. So...

Q. Let me ask you this --

A. Yeah.

Q. -- is there any -- is there any classification system currently in existence that -- that operates that way with regards to mental disorders?

A. Yes, there is.

Q. Which one?

A. The one that I employ at Johns Hopkins and we employ, the so-called Perspectives of Psychiatry. If you read that, you'll see that it strives to -- to generate a coherent distinction amongst conditions that relate to what a person has

is a diseases, to what a person is is a personality, what a person encounters is a life in a life, and that what a person is doing is a behavior.

And it wants to make a distinction and it struggles to show the data that relates to those distinctions between diseases, dimensions, behaviors, and life stories or life encounters. Yes. And where --

Q. And the -- this is the Perspective in Psychiatry that was published in the 1980s; is that right?

A. Yes. And -- and the second edition in the 1990s I believe. Yeah.

Q. And second edition in 1998?

A. Yeah, that's right.

Q. Is this the -- is Perspective in Psychiatry the -- commonly used within the field of psychiatry to make diagnoses?

A. It's commonly used at Johns Hopkins all the time and it's making headway elsewhere.

Q. All right.

A. I don't know how much it's going anywhere, but -- let's put it this way. That -- you asked is there an alternative classificatory system and I'm saying yes, there is this one.

Q. But is it widely -- what I'm asking as a follow up -- I accept your answer.

A. Yes.

Q. Is it -- is it the widely-used system of classification used in the field of psychiatry?

A. I wish it were more widely used and it will eventually be so, but right now it is a -- a proposal. You asked me to begin with is there anything out there and actually --

Q. No. No. Yeah. I appreciate it. I mean, I guess what I'm trying to get at is --

A. Okay.

Q. There -- there is --

A. You know, the real problem here is that once you have a field guide, it's very hard to get somebody to do something else because it requires

look at it in relationship to disorders of the skin or the heart or the -- the stomach or something, will show you what a real classification is like.

Q. Okay. And the definition of gender incongruence in the ICD is quite similar to the definition of gender dysphoria in the DSM; is that right?

A. That's right. It uses all the same stock phrases.

Q. In your report you make reference to a statement by Thomas Insel, the then director of the National Institute of Mental Health, that it -- that the NIMH would be reorienting its research away from the DSM categories. Do you recall that?

A. I do. I recall that, yes.

Q. Okay. Do you understand that Dr. Insel -- Dr. Insel's statement pertained to the NI -- the NIMH establishing the Research Domain Criteria project?

A. Yes, I do.

Q. Okay. And you understand that

Dr. Insel's statement pertaining to the Research Domain Criteria project reflects a long-term goal to understand mental illness as disorders of brain structure and function?

A. I -- I understand that, yes.

Q. Okay. Were you aware that two weeks after the statement that you referenced with regards to Dr. Insel he issued a joint statement with the American Psychiatric Association stating that "The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders along with the International Classification of Diseases represents the best information currently available for clinical diagnosis of mental disorders"?

A. I wasn't aware of that, but it doesn't surprise me.

Q. Okay.

MR. GONZALEZ-PAGAN: Let's mark up the joint statement, Lauren.

(Whereupon, Exhibit No. 6 was marked for

identification.)

MR. GONZALEZ-PAGAN: Just to preview, John, I think what I'm going to do is finish with this exhibit and line of questioning and then we can do a lunch break, if it works for people.

MR. KNEPPER: That was going to be my thought, Mar, is sort of get the DSM conversation completed, if -- if that's -- if that's where we're close, and then we can take a lunch break.

MR. GONZALEZ-PAGAN: Yeah, that sounds good. Let's do that. All right. If we can zoom in a little bit, Lauren. All right.

BY MR. GONZALEZ-PAGAN:

Q. Dr. McHugh, I'm showing you what's been marked as Exhibit 6. It is a news release by the American Psychiatric Association issued on behalf of Thomas R. Insel, M.D., Director of NIMH, and Jeffrey A. Lieberman, M.D., president-elect of the APA. Is that right?

A. Yeah.

Q. Okay. Let's just go to the second

paragraph. And we can zoom a little bit into that.

A. Yes. Yes, sir. Okay.

Q. I'm just going to read it. "Today the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders along with the International Classification of Diseases represents the best information currently available for clinical diagnosis of mental disorders.

Patients, families, and insurers can be confident that effective treatments are available and that the DSM is the key resource for delivering the best available care.

The National Institute of Mental Health has not changed its position on DSM-5. As the NIMH Research Domain Criteria project website states, the diagnostic categories represented in the DSM-4 and the International Classification of Diseases 10 containing virtually identical disorder codes remain the contemporary consensus standard for how mental disorders are diagnosed and treated." Did I read that correctly?

A. You did.

Q. Okay. And just to clarify, you were not aware about this joint statement by Dr. Insel with the APA?

A. I wasn't aware of it, but there you are.

Q. Do you think it is important information to put into context the statement that you included from Dr. Insel with regards to the DSM?

A. No.

Q. Why not?

A. Well, because I think that it's still discussing -- he discussed when he was at the NIH the reasons why they were dissatisfied with the DSM and he's here just reassuring everybody that what he has done shouldn't be taken as radical as many people have taken it. You know, he was --

Q. Well, I --

A. He was -- he was saying at one time that -- at the time when he was proposing the Research Diagnostic Domain Criteria, that something needed to change.

What he's saying here is although something needs to be changed, what they -- what he believes now is that this remains the standard for which mental diagnoses are diagnosed and treated. But if you tried to get a research project that was resting only on that rather than a reference to the Research Domain Criteria, you wouldn't get it from the NIH. It doesn't say that as well.

Q. Okay. Thank you. If we go down a little bit more closer to the bottom, just reading the last three sentences of the -- what appears to be the third-to-last paragraph.

A. Yeah.

Q. It starts "RDoC is a new comprehensive effort to redefine the research agenda for mental illness. As research findings begin to emerge from the RDoC effort, these findings may be incorporated into future DSM revisions and clinical practice guidelines, but that is a long-term undertaking.

It will take years to fulfill the promise that this research effort represents for

transforming the diagnosis and treatment of mental disorders. Did I -- did I read that correctly?

A. Yeah.

Q. Okay. And just to sum, the position of the NIMH seems to be we want to move towards a more research-based understanding of mental disorders and their causes, but we're not discrediting the DSM as a method for diagnoses at the time at the present?

A. I'm -- yes. Yes. And your point?

Q. Great.

MR. GONZALEZ-PAGAN: Okay. All right. That looks good. I think we can -- we can take it off, Lauren. We'll take a break for lunch.

THE WITNESS: Okay.

MR. GONZALEZ-PAGAN: Would an hour suffice?

THE WITNESS: That would be wonderful. But, you know, whatever -- whatever fits with you.

MR. GONZALEZ-PAGAN: Well, I'm asking -- I'm asking everybody here, including you.

MR.GONZALEZ-PAGAN: So let's do this. Let's come back at 1:15.

THE WITNESS: 1:15? Fine. Fine with me.

MR. GONZALEZ-PAGAN: And we'll reconvene then.

MR. McINNES: All right.

THE WITNESS: Okay.

VIDEOGRAPHER: Okay. We are going --

THE WITNESS: That will be --

VIDEOGRAPHER: We are going off the record. The time is 12:11 p.m.

(Whereupon, a brief recess was taken.)

VIDEOGRAPHER: We're back on the record. The time is 1:15 p.m. This is media number three.

BY MR. GONZALEZ-PAGAN:

Q. Dr. McHugh, earlier you had testified about how for some of the 30 to 35 transgender patients for whom you've consulted you've referred some of these to Fred Berlin --

A. Yeah.

Q. -- psychiatrist at Johns Hopkins himself; is that right?

A. Yes. Right. That's right.

Q. Okay. And my understanding is that he is a director at the Sex and Gender Clinic at Johns Hopkins Hospital?

A. He is now, yes. Mm-hmm.

Q. Okay. And my understanding is that the Sex and Gender Clinic works in collaboration with the Transgender Health Center that has been now established at Johns Hopkins; is that right?

A. They do. They collaborate with them, yes. Mm-hmm.

Q. Okay. Thank you. Let's go to paragraph nine of your report.

MR. GONZALEZ-PAGAN: Lauren, if we could pull the report up, that would be great.

THE WITNESS: Uh-huh.

BY MR. GONZALEZ-PAGAN:

Q. In this paragraph, Dr. McHugh, you speak of the Transgender Treatment Industry as a

comes out of a checklist out of DSM. You satisfy these criteria; therefore, you get this treatment. Not a good solid workup. I mean, that's what we were talking about this morning.

Q. Would you agree that there are -- there are some people for whom their gender identification is inconsistent with the sex they were determined to be at birth and that they don't have any other co-occurring conditions?

A. I believe that all of these patients -- I hold that all of these patients have a disorder of assumption and that although it's conceivable that some of them may well have a genetic -- some chromosomal abnormality, that's what needs to be demonstrated, not -- not simply presumed. And that's what I'm objecting to; they're often presumed.

So I -- I have no idea whether there might -- and how many might be due to a genetic cause and -- because nobody has given me any evidence for any of it.

able to independently observe particular -- in their meetings with their patient particular behaviors and/or expressions?

MR. KNEPPER: Objection.

THE WITNESS: Obviously, that's part of my job as a teacher and a builder of the Department of Psychiatry is to make clinicians of the sort that would look for more than one hypothesis for the explanation of something that was reliably recognized, but not validly understood. Yes, that's exactly what we're trying to do.

BY MR. GONZALEZ-PAGAN:

Q. Okay. So as I understand your critique, and correct me, part of your critique, is that the so-called Transgender Treatment Industry, somebody comes in, says this is my gender identity, and they're immediately referred to for medical and surgical care based on that self-report?

A. Yeah. Well -- yes. That's my objection to it. I find that it was very often, very often that the patients weren't sufficiently studied

before a prescription was offered.

They met criteria for gender dysphoria in DSM terms and with that, the presumption was there's one standard treatment and that is offered to them and that's what I'm -- one of my main objections here.

Q. Okay. So would your objection then be moot if you were informed that a clinician actually engaged in a detailed psychiatric interview and various visits with the patient in order to corroborate their self-report?

MR. KNEPPER: Objection to form.

THE WITNESS: I would be helped along the way. I would like to know what it is, especially if a radical treatment which the benefits are uncertain as often, you know.

After all, I have -- I have seen doctors who have said they've done a good study of a patient and said that probably a frontal lobotomy would help them. After all, I go back a long while.

I wanted to encourage him to go on with that because I had my serious doubts about this matter.

Q. What gave rise -- what gave rise to your doubts?

A. Well, just I saw some of the patients and they looked -- and this -- this is before I came to Baltimore, but I saw some of them in Oregon and I -- I thought they looked like caricatures of -- of women and I very much doubted that they were benefiting from it, but I wasn't certain.

Q. Don't you think it is pejorative to refer to transgender women as caricatures of women?

A. No, I don't think it's pejorative if it's true.

MR. KNEPPER: Objection; form.

MR. GONZALEZ-PAGAN: Lauren, let's mark Exhibit -- that's Dr. McHugh's Psychiatric Adventure -- Misadventures.

(Whereupon, Exhibit No. 7 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

things. It writes about scientific matters. Science after all is discussed outside of peer-reviewed articles, you know. It's discussed and debated and this is in addition to that debate that I was invited to contribute.

Q. Let's go to page 501 of the article and let's zoom in to the second-to-last paragraph, please. We're just going to read the last sentence of that paragraph.

"It was my intention when I arrived in Baltimore in 1975 to help end it." Did I read that correctly?

A. You did, yes. Mm-hmm.

Q. And it is in reference to sexual reassignment surgery; is that right?

A. That's right, yes.

Q. Okay. So is it safe to say that you had already made up your mind to end the provision of this care when you arrived at Johns Hopkins in '75?

A. No. No, that's not correct. It is -- it's -- what this really means is when I came to

avoid what they had undergone, I would have done that. So anyway, there you go.

Q. Why weren't you impressed?

A. Well, as I said, I thought they were -- they were men masquerading as women.

Q. Did you speak with these patients?

A. Yeah. Yes, I did. But, you know, not more than -- I was -- I was the director of the -- of the department there and I was being shown these by a member of the department.

Q. Had you looked into the literature at the time --

A. I had -- no, it -- it was my -- it was my first encounter with this. Ira Pauly, who was the -- who was the most distinguished psychiatrist out there, was working on picking up on this idea and was showing some of the patients. They did it at their grand rounds there and I was, as I said, not impressed that these patients had been benefited. Mm-hmm.

Q. And you haven't conducted any independent

research of your own into the efficacy of sex reassignment surgery at the time?

A. No, I didn't. No. But it was already going on at Hopkins when I arrived and I encouraged it.

Q. Later in the article, if we go to page 503 --

A. Yes.

Q. -- I think it's third-to-last paragraph --

A. Yeah.

Q. -- I'm going to read that first sentence. "Moral matters should have some salience here."

A. Yes.

Q. Did I read that correctly?

A. Yes. Yes.

Q. What did you mean by that?

A. Well, let me just get it again. Where -- where is it? I -- I know I said that, but I can't find it. So I know if it is --

Q. Sure. Yes. We can -- can you see my --

the cursor?

A. Yes, I can see your cursor. No, I can't see your cursor. Let me -- I mean, I know it's in here. I -- yeah, there it is. "Moral matters..." Yes, I've got it. Yeah, "...should have some salience here." Yes. What do you want to know?

Q. What did you mean by that?

A. Well, I followed on with it, didn't I? I said "These include the waste of human resources, the confusions imposed on society where men and women insist on acceptance, even in athletic competitions with women, the encouragement of the illusion of technique, which assumes that the body is like a suit of clothes."

All of those are -- and finally, the ghastliness of the mutilated anatomy. All of those are moral matters.

Q. Do you think moral concerns should affect whether somebody is able to obtain care?

A. Excuse me. I'm -- I'm not sure I understand that.

Q. Did he have -- did he share the same concerns that you had?

A. No. He was very sure that he was doing -- the exercises that he was doing were -- were only beneficial. Yeah.

Q. In the just under 50 years since you've became psychiatrist-in-chief, you, yourself, have not sought to conduct any primary research to address the concerns that you have; is that right?

A. No. That's right.

Q. And you -- who made the decision to stop providing medical and surgical care at Johns Hopkins?

A. Well, it -- it was -- I suppose it was a departmental-wide decision, but of course I led that because I was leading the department. So I in looking at the Meyer data that came along, I said that I didn't think that we should continue it. And so we stopped.

Q. And did you advocate against its reopening while you --

and followed on after the Meyer study seemed to confirm and, in fact, enhance what the Meyer study had demonstrated.

Q. And to which Swedish study are you referring to?

A. The -- the John Meyer and Ryder study that was done in 1979.

Q. Sorry. That's the Meyer study?

A. Yes.

Q. But you mentioned a --

A. Yes.

Q. -- a Swedish -- a Swedish study.

A. A Swedish study, Dhejne's study, that followed for 30 years the people treated with transgender surgery in Sweden.

Q. The Dhejne study that was published in 2011; is that right?

A. That's right. That's the one. Yes, sir.

Q. Okay. What do you believe that the Dhejne study showed?

A. It showed that the -- that the patients

that had the transgender surgery, their suicide rate was 19, close to 20 times the general populations and that they had a -- a variety of further troubles that began about 10 years after the surgery.

Q. That was comparing the transgender population postsurgery to the general population at large; is that right?

A. That's right. Yes.

Q. Wouldn't the apt comparison for the conclusion to which you are referring, would it have been comparing postsurgical patients with presurgical patients?

A. Well, it -- it would have been, but they didn't do that. But after all, the Meyer study did compare patients with other patients and the Branstrom study did the same afterwards.

But the, you know, the Dhejne study was powerful in the fact that it really did do what one wanted, namely do a complete follow-up of everybody.

Q. And -- but the Dhejne study only shows that transgender people even after surgery have a higher incidence of suicide when compared to the general population at large. That's all that it showed; is that right?

A. That's something, isn't it?

Q. Well, I wouldn't be surprised by that. Wouldn't --

A. Twenty times? Nineteen times more? Oh, you'd be surprised by that, Dr. Gonzalez.

Q. Wouldn't it be -- wouldn't it be -- I wouldn't be surprised given the social stressors. So I guess my question is: Wouldn't it be an alternative hypothesis that that difference compared to the general population at large is due to social stigma, oppression, and/or discrimination?

A. Yeah, you'd think that and particularly in other countries besides Sweden. Sweden is a very accepting country. You know, this social pressure or social stigma argument is being used to

-- to justify this thing, but it -- I must say I don't see it as powerful as people claim. But, you know --

Q. But it is still an alternative hypothesis?

A. Oh, it's an alternative hypothesis and it needs to be studied. Absolutely. But meanwhile we probably should stop if 20 times suicide continues. It's not doing people a lot of good.

Q. Well, how do you know that it's not doing good? It didn't -- it didn't do a comparison pre and postsurgical?

A. It's not doing good because it's evident that it's not doing good yet and it's up to them to show where the evidence -- where the good is and we didn't find any good out -- out of the Meyer study.

Q. Okay.

A. You see, it was -- it was -- you know, the -- the fact that the Meyer study showed that the patients really weren't better in the claims -- in the things that they claimed that they would be

discovered in doing this and it was very unexpected. No one expected to find a 20 times increase in suicide amongst those patients. They would never have started this treatment if they were going to find that result.

Q. Are you aware that Cecilia Dhejne has said that that is a mischaracterization of her study?

A. I -- I'm very well aware of it that, you know, that's what her claim is, but this is what anyone who reads the data would ordinarily feel.

Q. You say anyone who would read the data.

A. Yes. Yes.

Q. Are you aware that multiple people have read the data and do not come to that same conclusion?

A. Yes, I am aware of that.

Q. Okay.

A. But they were not looking closely at what the implications might be in my opinion. In my opinion they did not carefully and -- think about

their role in -- their role as doctors. They were not --

Q. I don't -- I don't mean to be combative with these questions.

A. No, that's fine. That's fine.

Q. But I -- are you saying that the only way that somebody would have -- the only way to prove that somebody looked at the data is that they came to the same conclusion as you did?

A. Well, it's close to that. It seems to me this is so -- this is almost black and white, Mr. Gonzalez, it seems to me. But you know, obviously people are disagreeing, but I think they're disagreeing because of the social pressures that are felt still. I -- I -- I don't --

Q. Well, you're quoting the author, right?

A. I don't know -- I don't know how many other bodies have to accumulate before people start -- start saying, you know, this isn't a good idea, but it will -- it will come.

Q. What is the incidence of suicide for

would want in talking with my endocrine colleagues to talk about that matter.

Because it turns out that the use of -- of puberty blockers seems to alter the ultimate results of patients, young children, with gender dysphoria. The majority of them, 70 to 80 to 90 percent of them, lose this gender dysphoria going through puberty and therefore are not interested in cross-sex hormones or surgery; whereas, once you start them on this, puberty blockers, almost 90 percent of them go the whole way it seems.

At any rate, that's the -- that's the present data that I know and that means to me that something has organized them or reorganized their brain or made them at least more suggestive to further treatment that comes along with accepting the treatment of the -- of the puberty blockers.

And that may be simply a psychologically phenomena, but it may well be a biological phenomenon demonstrating that some of the reversibility that's claimed doesn't happen. But

Q. Do you know what studies were being referenced in the DSM-5?

A. I -- I have no idea, but I think there are several.

Q. Do you know that those studies have to do with children diagnosed with gender identity disorder as opposed to gender dysphoria?

MR. KNEPPER: Objection; form.

THE WITNESS: I'm -- I'm not sure I understand the difference there --

BY MR. GONZALEZ-PAGAN:

Q. Well --

A. -- that you're trying to draw.

Q. -- would you agree that the gender identity disorder diagnosis is distinct from the gender dysphoria diagnosis?

A. Yeah. Well, I agree that in DSM they are trying to make that distinction and I'm not sure I understand it. And I don't think it's necessarily valid.

Q. It could be that some of the children

diagnosed with gender identity disorder were indeed simply not transgender to begin with?

MR. KNEPPER: Objection; form.

BY MR. GONZALEZ-PAGAN:

Q. Would you agree that there -- that an alternative --

A. I believe -- I believe they're all capable of -- of changing and as far as I know, nobody is making these distinctions that you are trying to draw here for me.

And I know that these patients, these subjects rather, if let alone, they desist. But they are to begin with and how they are distinct is for somebody else to show me, okay.

But as far as I know, the evidence right now is to say if somebody says they don't -- their -- their sex of opinion and the sex of their body are discordant -- discordant, they change and become concordant in 80 to 90 percent of the cases if they're allowed to go through puberty. That I know.

purpose. Its purpose is over, okay. It's -- that purpose has been settled. We can go on now and should be using more intelligible, coherent approaches to classification than a field guide.

Q. Do you -- in speaking about this 70 to 80 percent statistic just now, you made reference to the word change, that these children were able to change from their cross-gender identification, did you not?

A. Did I use the word change? Well, they abandoned it.

Q. I believe you did, but I'm asking you.

A. Well, what I -- what I just meant was that they abandoned the idea that they were somehow in the wrong sex. They were the -- you know, their sex of opinion and their sex of the body were misaligned.

Q. Do you believe that transgender patients should you be encouraged to align their identity and presentation with the sex they were determined at birth?

A. Wouldn't you? Wouldn't that spare them a long lifetime of hormone treatments and constantly dealing with doctors and things of that sort? Finding themselves to be what they were born -- they were made in conception. Oh, yes, I think that this -- that would -- if we could do that, we would all do that.

Q. Do you believe that that's effective?

A. I think that it would be. I think it would be effective and I think going through puberty is one of the ways that they -- that those kinds of things come back into alignment.

Q. I guess what I'm asking is: You oppose the provision of hormonal and surgical care for the treatment of gender dysphoria, you have noted throughout that -- that your clinic -- that the clinic at Johns Hopkins continued to provide psychiatric care, and I guess what I'm wondering is what is the psychiatric care that you believe should be provided to transgender people --

A. Yes.

Q. -- with gender dysphoria?

A. Well, it depends on various kinds of sources of their transsexual feelings, but amongst young children I think that there should be family therapy that looks into the reasons why the person is dissatisfied with their sex at conception.

Q. And --

A. And often you'll find that there are other kinds of other sources of discouragement, depression, and sometimes abuse, sexual abuse, things of this sort. And those things should be dealt with. Those should be dealt with psychologically.

Q. And if the young person persists in their cross-gender identification into adults and adulthood, what then?

A. Well, they can do whatever they please.

Q. Except --

A. I -- I would --

Q. -- get hormonal and medical care?

A. But I -- I think that they -- you know, I

-- I think that if they persist -- we have -- we have lots of disorders of assumption that appear in adolescence and persist into adulthood, but we still try to help people with them. The best example being anorexia nervosa.

It is a condition that springs up usually amongst young women in their early teens and -- but it can extend right into long life with people and they often need counseling and support to get them to eat satisfactorily enough to keep them at least reasonably healthy even though they continue to have the fear of fatness that is fundamental to this. This is -- this is not new, that -- it would -- it would continue.

Q. What's the goal of the therapy?

A. What's the role of the therapy?

Q. The goal.

A. The goal --

Q. What's the goal of the therapy?

A. The goal of the therapy is explain to the patients right off the bat is to lead them to move

from an idea that is unreal to the reality world that they need to live in and they should live in.

Q. I guess to clarify --

A. And that they would flourish -- they would flourish better if they did that we think.

Q. Just to clarify, when you talk about shifting from the idea to the real, do you mean to align their identity with the sex that they were determined at birth?

MR. KNEPPER: Objection; form.

THE WITNESS: Once again, the sex was -- was --

BY MR. GONZALEZ-PAGAN:

Q. That's semantics, but --

A. -- received at conception. Their sex was -- has been from conception. Let's call it -- let's just call it for the sake of argument natal sex, okay? That's fair enough.

Q. Great.

A. We can do that.

Q. Fair enough. We'll use that terminology.

A. I think -- I think people do better and live better and flourish better and need less help from -- from doctors if their natal sex and their attitude towards their -- their own sex is the same.

Q. Are you aware that the American Psychiatric Association opposes conversion therapy efforts?

A. Oh, I know the American Psychiatric Association -- its -- its views about any of these conversion therapies and I think that we often mistake the idea that -- that -- this is something that we're trying to force on patients or something that we're trying to do for their benefit, you know.

Q. Okay.

A. I think the benefit of patients is that they -- they do better the more they're aligned with reality, not what is possibly true. It's true regardless of whether anyone believes it or not.

MR. GONZALEZ-PAGAN: Lauren, let's look

A. I do, yes, sir. Yeah.
Q. Okay. And it is titled Transgender, Gender Identity, and Gender Expression Non-Discrimination. Do you see that?
A. I do. I do see that. Yeah.
MR. GONZALEZ-PAGAN: If you go to -- give me one moment. I apologize, Lauren. This is the wrong resolution. There's two. Let's introduce the other one. We'll leave this one marked as 11.
MS. EVANS: Sorry about that.
MR. GONZALEZ-PAGAN: That's okay. They're both called APA resolutions.
MS. EVANS: Give me a second. Hopefully this is the right one.
MR. GONZALEZ-PAGAN: Yes.
(Whereupon, Exhibit No. 12 was marked for identification.)
BY MR. GONZALEZ-PAGAN:
Q. Dr. McHugh, I'm showing you what's been marked as Exhibit 12. Do you see that?
A. Yes. Okay. Yes. Right.

Q. Okay. And it is a resolution by the American Psychological Association --

A. Yes.

Q. -- on gender identity change efforts. Do you see that?

A. I do. I see that, yes.

Q. Okay. And it is dated February 2021. All right. Let's go to the second page and zoom in at the bottom.

A. Yeah.

Q. On the third-to-last paragraph in that second column, one of the whereas statements, it states "Whereas, GICE have not been shown to alleviate or resolve gender dysphoria (Bradley and Zucker, 1997; Cohen-Kettenis and Kuiper, 1984; Gelder and Marks, 1969; Greenson, 1964; Pauly, 1965; and SAMHSA, 2015)" Did I read that correctly?

A. Yes. Yes.

Q. Do you understand GICE to mean gender identity change efforts?

A. Yeah.

Q. Okay. And the American Psychological Association is citing to a number of scientific articles in support of that statement that they make there; is that right?

A. Yes.

Q. Okay. Including one by Ira Pauly --

A. Yes.

Q. -- that you earlier discussed?

A. Yes. Yes.

Q. And including one by Ken Zucker; is that right?

A. Yes. Yes. I see that, yes. It's very interesting that -- that he would be quoted in that given that he has demonstrated that with 25 patients -- he studied children, young people, with gender or sex disorder -- that 24 or 25 of them he was able to alleviate. So I'm -- I'm surprised to see that. Anyway...

Q. And Ken Zucker believes that once a patient has persisted into adolescence and

adulthood, they should have access to hormonal and medical treatment; is that right?

A. Yes.

MR. KNEPPER: Objection.

THE WITNESS: Yes. Yes, he does. Yeah.

BY MR. GONZALEZ-PAGAN:

Q. Let's go to page three, the last two paragraphs, the first "Be it therefore resolved..." It states "Be it therefore resolved that consistent with the APA definition of evidence-based practice (APA, 2005) the APA affirms that scientific evidence and clinical experience indicate that GICE put individuals at significant risk of harm."

A. Yes.

Q. "Be it further resolved that the APA opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid GICE." Did I read that correctly?

A. You did.

Q. Okay. Is it fair to say that the American Psychiatric Association and the American Psychological Association both oppose therapeutic efforts to change a person's gender identity?

MR. KNEPPER: Objection; form.

THE WITNESS: Yes. Yes, that's right.

BY MR. GONZALEZ-PAGAN:

Q. And that -- is it fair to say that the American Psychiatric Association and the American Psychological Association both consider such efforts to be unethical and harmful?

MR. KNEPPER: Objection; form.

THE WITNESS: That -- that's what they say here.

BY MR. GONZALEZ-PAGAN:

Q. Thank you. All right. Let's go to -- let's show you your report again, Dr. McHugh.

A. Okay.

Q. Let's go to paragraph 10 of your report on page 12.

A. Yes.

EXHIBIT B

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

- - -

MAXWELL KADEL, et al.	)	
	)	
Plaintiffs	)	Case No.:P
	)	
vs.	)	1:19-CV-00272-LCB-LPA
	)	
DALE FOLWELL, et al.	)	
	)	
Defendants	)	

- - -

FRIDAY, OCTOBER 29, 2021

VOLUME 2

- - -

Continued remote videotaped deposition of PAUL R. McHUGH, M.D., was taken on Friday, October, 29, 2021, commencing at 9:46 a.m., before Rebecca L. Schnur, Notary Public

- - -

Reported By: Rebecca L. Schnur

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DEPOSITION OF PAUL R. McHUGH, M.D.

EXAMINATION INDEX

- - -

EXHIBIT INDEX

(Exhibits attached to transcript.)

Q. Is there a particular calculation that you do to define what a reasonable degree is?

MR. KNEPPER: Objection. Form.

A. I do, on the foundations of an opinion. There are sources in science that -- applications, when reported, and the degree of confidence in which people are proceeding.

Q. Okay. Is there a specific degree of certainty here, like 95 percent confidence, like -- or something like that?

A. No. I don't -- I don't suppose there is, especially in a contested opinion.

Q. Is there an error rate for what is a reasonable degree of medical certainty?

MR. KNEPPER: Objection to form.

A. In this area, there isn't. Yeah.

Q. If we can turn to page 14 of this document --

A. Sure. Yes.

Q. -- and in the second-to-last paragraph here --

A. Yeah. Yes. 14.

Q. -- sorry, third-to-last paragraph, do you see that, where it says -- you state, as one of the summaries you're repeating is that, quote, "Affirmation ('transgender transitioning') medical treatments -

hormones and surgery - for gender dysphoria and 'transitioning' remain unproven and thus not been accepted by the relevant scientific communities (biology, genetics, neonatology, medicine, psychiatry, psychology, et cetera.)"

A. Yes.

Q. Did I read that correctly?

A. You did, sir.

Q. Okay. What is the relevant scientific community to which you refer when you state that gender-affirming medical treatments have not been accepted by the relevant scientific medical communities?

A. It's just the plain ordinary medical community of practitioners, especially practitioners at the forefront of this matter.

MR. GONZALEZ-PAGAN: And, Lauren, we can stop the screen scare.

Q. Mr. McHugh, are you familiar with the National Academy for Medicine, formerly known as Institute of Medicine?

A. I'm a member.

Q. You're a member.

Would you consider that to be part of the relevant scientific community?

A. It is an organization that is a contemporary scientific and medical community. And I don't -- I'm not sure that their opinion, really, on these matters are ones that I would always accept, no.

Yes. So it's a complicated thing. I think it's a relevant community, but not a commanding community.

Q. Okay. Are you familiar with the National Academy for Science?

A. Yes.

Q. Okay. And would your opinion be the same, that it is a relevant community?

A. Yes.

MR. GONZALEZ-PAGAN: This is a large PDF, but I'm introducing what's been marked as Exhibit 15, continuing the enumeration from the beginning of the deposition on September 8.

Lauren, if you can screen share Exhibit 15.

(Whereupon, Deposition Exhibit 15 was marked for identification.)

MR. GONZALEZ-PAGAN: We can turn to page 2 of that exhibit.

THE WITNESS: Yes.

BY MR. GONZALEZ-PAGAN:

Q. Dr. McHugh, I'm showing you what's been

titled -- what is titled, "Understanding the Well-Being of LGBTQI-plus Populations." And it appears to be a consensus study report of the National Academies of Sciences, Engineering and Medicine.

Do you see that?

A. I do, sir.

MR. GONZALEZ-PAGAN: Okay. If we go on to the next page -- and I'll note for the record that this exhibit contains some highlighting that is not part of the original, that has been done by me. There are no other alterations to the document.

Actually, if we go to what would be page 5 of the PDF -- and we can zoom in there a little bit -- the prior page.

BY MR. GONZALEZ-PAGAN:

Q. Dr. McHugh, it states, that a "Consensus study" report "published by the National Academies of Sciences, Engineering, and Medicine document the evidence-based consensus on the study's statement of task by an authoring committee of experts," that the "Reports typically include findings, conclusions...recommendations based on information gathered by the committee and the committee's deliberations. Each report has been

subjected to a rigorous and independent peer-review process and it represents the position of the National Academies on the statement of task."

Did I read that correctly?

A. You did, sir.

Q. So would you agree with me that it appears that this document, as a consensus study report, is both the official position of the National Academies and that it is a document that was subjected to an independent peer review?

A. Yes. That's what it says, yeah.

MR. GONZALEZ-PAGAN: If we go to the page 311 of the PDF, Lauren. It's page 12-10 of the document.

MR. KNEPPER: Omar, one second. I'm still having trouble pulling up the exhibit.

Do the other counsel have access to it through exhibit share?

MS. EVANS: Yes, John. Actually, what I'm sharing on the screen is from the marked exhibits folder.

MR. KNEPPER: Yeah. That's what I -- I was hoping you'd say that because I've just -- I've still got only 14.

MR. GONZALEZ-PAGAN: So it's a different

folder for today, John.

MR. KNEPPER: Got it. Okay. I see what's going on here. Yep. Got it.

Okay. Thank you for your time. Yeah. Okay. Great. Thank you.

MR. GONZALEZ-PAGAN: We can zoom in on that a little bit more, Lauren.

BY MR. GONZALEZ-PAGAN:

Q. The consensus study report on this page, page 12-10 of the report, states, "Clinicians who provide gender-affirming psychosocial and medical services in the United States are informed by expert evidence-based guidelines. In 2012, the World Professional Association for Transgender Health (WPATH) published version 7 of the 'Standards of care for the Health of Transgender, Transsexual, and Gender-Nonconforming People,' which have been continuously maintained since 1979, and revisions for version 8 are currently underway (Coleman et al., 2012.) Two newer guidelines have also been published by the Endocrine Society (Hembree et al., 2017) and the Center of Excellence for Transgender Health (UCSF Transgender Care, 2016). Each set of guidelines is informed by the best available data and is intended to be flexible and holistic in application to individual

people. All of the guidelines recommend psychosocial support in tandem with physical interventions and suggest timing interventions to optimize an individual's ability to give informed consent. Mental and physical health problems need not be resolved before a person can begin a process of medical gender affirmation, but they should be managed sufficiently" so "that they do not interfere with treatment."

Did I read that correctly?

A. You did, sir.

Q. Will you agree that it is, then, the official position of the National Academies of Medicine, Science, and Engineering that the provision of gender-affirming psychosocial and medical services for the treatment of gender dysphoria is informed by expert evidence-based guidelines, including the WPATH standards of care?

A. Well, that's what it says.

MR. GONZALEZ-PAGAN: We can stop sharing this exhibit.

I'm introducing what's been marked as Exhibit 16.

(Whereupon, Deposition Exhibit 16 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

Q. Mr. McHugh, would you consider the American Psychiatric Association to be part of the relevant scientific community when it comes to these questions?

A. Do I consider them -- well, I consider them part -- yes, I consider them part of -- yes, they're part of the community, yes.

MR. GONZALEZ-PAGAN: We're showing you -- Lauren, if we could screen share Exhibit 16.

Q. This is the position statement of the American Psychiatric Association on "Access to Care for Transgender and Gender Diverse Individuals."

Do you see that?

A. I do see it.

Q. Okay. Have you seen this document before?

A. Actually, I haven't, no.

Q. Okay. Have you seen the National Academies report before?

A. No, I hadn't.

Q. And the National Academies report was published in 2020.

Is there any reason why you were -- didn't look to what the National Academies have said on this question?

A. I don't think I had any particular reason.

MR. GONZALEZ-PAGAN: On this document, if we could zoom in on the center of the issue.

MR. KNEPPER: Just to clarify, what's the date on this document, Omar?

Q. Sure. Dr. McHugh, do you see where it says it was approved by the board of trustees of the American Psychiatric Association in July of 2018?

A. Yes, I do, sir.

Q. And it was approved by the assembly May 2018. Is that right?

A. I do. Yes. Uh-huh.

Q. It states -- just below the issue, it states that, "Significant and longstanding medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to assist gender diverse individuals seeking transition. However, private and public insurers often do not offer, or may specifically exclude, coverage for medically necessary treatments" of "gender transition. Access to medical care (both medical and surgical) positively impacts the mental health of transgender and gender diverse individuals."

Did I read that correctly?

A. Yes. I didn't follow you at first, but I think I'm following it now. Yes. I don't see that you

read it incorrectly, no.

Q. Okay. If we move a little bit further down on the document --

A. Yes.

Q. -- on position Number 3, it states that the American Psychiatric Association, "Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician."

Did I read that correctly?

A. You did, yes.

Q. Okay. Were you aware of this position of the American Psychiatric Association?

A. I was.

Q. Is there any reason why you didn't disclose this when you were stating that the relevant scientific community does not accept this position?

A. No, other than my opinion that this did not rest on a solid science foundation. The references that they all have made and looked at are weak, a weak proof for the medical necessity in many of the -- at least the hormonal and surgical treatment of these patients, so I disagreed with them.

Q. I agree -- I understand that, Dr. McHugh. I guess my question is, because your opinion is that this view has not -- about the medical necessity of this

treatment, quote, has not been accepted by the relevant scientific communities -- and I've just shown you two examples of the National Academies and the American Psychiatric Association that appear to say to the contrary.

And I'm just curious why you didn't disclose that in your report.

A. Because I didn't agree with it, I suppose. I didn't agree that they had -- actually, in their opinions, every time I did look, I know it was discussing the foundations, like in the Anderson Society. They agree that the foundations were not strong. So I believe that these represented more advocacy groups in this area than true full scientific evaluations of the benefit of these processes to the patient. I held that opinion and I still hold it to this day.

Q. Would you agree that the American Psychological Association also is in agreement that this medical -- that this medical treatment and hormonal and surgical treatments are medically necessary and beneficial to the transgender population?

MR. KNEPPER: Objection.

A. Yes. I understand that. Yes.

Q. Will you agree that the American Medical

Association also supports the provision of medical treatment for the treatment of gender dysphoria?

MR. KNEPPER: Objection to foundation.

A. I realize that these organizations have made these statements. What I've said and what I still hold is that the foundations on which they hold these opinions, they, themselves, agree are somewhat shaky, when they look at them individually and at the data that they show, that these do not represent the kind of evidence on which they would ordinarily support a treatment.

They've done this before, in other conditions, such as the multiple personality disorder, so I've seen this kind of approach to vexed social question.

Q. I understand that, Mr. McHugh. I guess --

A. Right, Counsel. I'm sorry. I beg your pardon.

Q. No. No. It's okay. I appreciate it.

MR. GONZALEZ-PAGAN: If we can stop sharing this exhibit, Lauren.

Q. Dr. McHugh, you made mention, for example, of the Endocrine Society, which you noted have published guidelines that were graded and were peer-reviewed.

Do you recall that?

A. Yes.

MR. GONZALEZ-PAGAN: Okay. I am introducing what's been marked as Exhibit 17.

(Whereupon, Deposition Exhibit 17 was marked for identification.)

MR. GONZALEZ-PAGAN: Lauren, if we could share it.

If we can zoom in, at the top.

BY MR. GONZALEZ-PAGAN:

Q. This appears to be a position statement on transgender health by the Endocrine Society and the Pediatric Endocrine Society.

Do you see that?

A. I do.

Q. I believe this is the same Endocrine Society to which you referred to as having done a graded look at the evidence in support of their guidelines. Is that right?

A. Yes.

Q. And if we go to the next page, at the bottom, at the very bottom, this appears to have been published in December 2020.

Do you see that?

A. I do, yes.

Q. Just a little bit on top, the second bullet

point under "Positions" --

A. Okay. Yeah.

Q. -- it states, "Medical intervention for transgender youth and adults (including puberty suppression, hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care. Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have."

Do you see that?

A. I do.

Q. Okay. So it is the view of this organization, which you referenced to have done an assessment of the evidence, that these medical interventions are effective, relatively safe, and have been established as the standard of care.

Is that right?

A. That's what it says, yes.

Q. Would you consider your fellow medical professionals at Johns Hopkins to be part of the relevant scientific community with regards to this question?

A. Some of them.

Q. Do you recall that last time we discussed the Johns Hopkins Center for Transgender Health?

A. I do, yes.

MR. GONZALEZ-PAGAN: Lauren, we can drop this exhibit.

I'm introducing what's been marked as Exhibit 18.

And Lauren, if we could show it.

(Whereupon, Deposition Exhibit 18 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

Q. This is a printout of the web page for -- the services and appointments page of the Center for Transgender Health at Johns Hopkins Medicine.

Do you see that?

A. I do. I see it, sir. Yes.

Q. Okay. And Johns Hopkins Medicine is where you are employed. Is that correct?

A. That is, yes.

Q. Okay. And as we discussed, they have a Center for Transgender Health?

A. It does.

Q. Okay. That first paragraph states, "The Johns Hopkins Center for Transgender Health offers

comprehensive, evidence-based and affirming care for transgender youth and adults that is in line with the standards of care set by the World Professional Association for Transgender Health."

Did I read that correctly?

A. You did.

MR. GONZALEZ-PAGAN: All right. We can take the exhibit down.

Q. Mr. McHugh, are you aware who -- are you familiar with Dr. Kenneth Zucker?

A. Yes.

Q. Okay. Would you consider Dr. Zucker to be part of the relevant scientific community?

A. Yes.

Q. Are you aware that Dr. Zucker supports providing hormonal and surgical care for the treatment of gender dysphoria to a transgender person whose gender dysphoria persists into adolescence?

A. I'm aware of Dr. Zucker's position on this, which he believes, from case to case, is very complicated, and sometimes he says that he feels that he should support this kind of treatment.

And I have disagreed with him on those matters. And he and I -- I have great respect for him, but we are in contention a little bit about what should

be done for youth. Most of the time, Mr. Zucker -- Dr. Zucker has recognized that most of these patients are not helped by -- are not benefited by these physical treatments.

Q. Well --

A. You can find plenty of evidence for that in his testimony, such that, ultimately, because of his position on these things, he was deprived of his position in Canada.

Q. And even then, he still provided this care for individuals whose gender dysphoria persisted into adolescence?

A. Yes, I gather he did, but very reluctantly, I believe, and not reluctantly enough, in my opinion.

I believe that these kinds of treatments should not be given to adolescents or anyone who is a minor.

Q. Just shifting gears, then, a little bit, last time, we briefly discussed some of your publications --

A. Yes.

Q. -- relating to the topic of gender dysphoria and transgender persons.

Do you recall that?

A. Yes, I do. I remember that very well, Counselor.

Q. And we established that two of those publications were the -- an article titled, "Sexuality and Gender Findings from the Biological, Psychological and Social Sciences," and the other, "Growing Pains, Problems with Puberty Suppression in Treating Gender Dysphoria."

Do you recall that?

A. I do, yes.

Q. Okay. Those two articles were published in "The New Atlantis." Is that right?

A. That's correct, sir. Yes.

Q. Okay. "The New Atlantis" is not a peer-reviewed journal. Is that right?

A. No, it wasn't. No.

Q. Is it a scientific journal?

A. No. It's an ordinary journal for the public. It's a public publication to inform the public about what the authors believe the scientific community has shown.

Q. Who published "The New Atlantis" at the time of the publication of these articles?

A. Who published it?

Q. Yes.

A. I don't know exactly who the publishers are.

Q. Are you familiar with the Center for -- the

Ethics and Public Policy Center?

A. Yes. I'm sorry. Yes. These are things that slip my mind. Yes, of course. And it was from that organization that this -- that "The New Atlantis" is one of its publications, yes.

Q. Are you aware that the Ethics and Public Policy Center represents itself as Washington, DC's premier institute dedicated to applying the Judeo-Christian moral tradition to critical issues of public policy?

A. Yes, I am. I'm aware of that, yes.

Q. Why did you decide to publish these articles in a journal published by an organization that was dedicated to applying Judeo-Christian moral traditions to critical issues of public policy?

A. It seemed an interesting organization and interesting publication to me.

Q. Is there any reason why you chose not to publish either of these articles in a peer-reviewed journal?

A. Because it's -- I didn't discover anything new. I wasn't describing anything new, which is what a peer-reviewed article is about.

This was my evaluation of what the peer-reviewed periodicals had shown. This is my

opinion of what peer-reviewed things -- it was not a new discovery. There were no new discoveries that were reported in that. It was an article of opinion, as you might find in "The Atlantic" or in "The New Republic" or in "The New Yorker."

Q. Thank you.

Were you aware of some of the criticisms of the "Sexuality and Transgender" article by medical and scientific professionals?

A. I'm very aware of it. None of them seem to attack any particular opinion by other evidence. Most of the attacks were that they didn't like my reading of the literature.

MR. GONZALEZ-PAGAN: I'm introducing what's been marked as Exhibit 19.

Lauren, if you could please share it on the screen.

(Whereupon, Deposition Exhibit 19 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

Q. This is a letter dated March 22, 2017. It starts by saying, the "Sexuality and Gender" report published in "The New Atlantis" by you and Dr. Lawrence Mayer -- the first -- the first page contains the letter, and there are another 35 pages or so of

signatories.

A. Yes. Yes. I'm aware of that, yes.

Q. Yeah. Are you familiar with this letter?

A. I am.

Q. In its last sentence, the letter states --

MR. GONZALEZ-PAGAN: And if we can zoom in, Lauren, that would be great.

Q. -- "In summary, as researchers and clinicians with expertise in gender and sexuality, we affirm that the 'Sexuality and Gender' report does not represent" the "prevailing expert consensus opinion about sexual orientation or gender identity related research or clinical care."

A. Yes. Yes.

Q. Were you aware of this critique?

A. I was. I was, very much so, yes.

Q. Would you agree that the various doctors, researchers, and healthcare medical professionals that signed this letter are part of the relevant scientific community?

MR. KNEPPER: Object to form.

A. They are, yes. I suppose they are, yeah.

I've always supposed that they were, demonstrating, of course, that -- how contended this field is. Experts that disagree.

MR. GONZALEZ-PAGAN: Let's exit this share.

And I'm introducing what's been marked as Exhibit 20.

(Whereupon, Deposition Exhibit 20 was marked for identification.)

MR. GONZALEZ-PAGAN: Lauren, if you could please share as soon as it publishes.

BY MR. GONZALEZ-PAGAN:

Q. Mr. McHugh, were you aware of some colleagues at Johns Hopkins that criticized your publication of the "Sexuality and Gender" report?

A. I'm very aware of that, yes.

Q. Okay. I am showing you what is a printout of an op-ed in "The Baltimore Sun." It was by --

MR. GONZALEZ-PAGAN: If we can zoom in to the authors.

Q. -- Drs. Chris Beyrer, Robert Blum, and Tonia Poteat, who are -- who represent themselves to be faculty at Johns Hopkins.

A. Yes.

Q. It was published in September of 2016. And this printout was printed into PDF on -- if we can go to the top -- on September 7, of this year.

Were you aware of their critique by these faculty colleagues at Johns Hopkins?

A. Yes.

Were you, Counselor, aware of my response to this in another editorial that followed a couple of weeks later?

Q. If we go to the second paragraph, it states, "As faculty at Johns Hopkins, a major educational, research and health institution, we are writing to express our concern about a recently published report that we believe mischaracterizes the current state of the science on sexuality and gender."

A. Yes.

Q. Were you aware that faculty colleagues at your institution thought that you were mischaracterizing the science in your report?

A. Well, these ones did, yes.

MR. GONZALEZ-PAGAN: We can exit the exhibit.

A. As you can see, the first sentence of that article is -- demonstrates how lack of experts they are, in university life.

Q. Are you familiar with Dean Hamer?

A. Yes.

Q. Dean Hamer is a geneticist. Is that right?

A. Yes. A distinguished person, yes.

Q. Are you aware that he criticized your "Sexuality and Gender" article?

A. I am.

Q. Would you consider Dean Hamer to be part of the relevant scientific community to which you refer to in your report?

A. He's certainly relevant.

Q. Would you consider Dr. Lawrence Mayer to be part of the relevant scientific community?

A. Yes. Yes.

Q. And Dr. Mayer was your coauthor in the "Sexuality and Gender" and "Growing Pains" articles. Is that right?

A. That's right. Yes.

Q. How did you come to work with Dr. Mayer on the "Sexuality and Gender" article?

A. Dr. Mayer was a member of my department of psychiatry and he is an expert statistician. And I very much appreciate his enterprise in understanding the statistics of complicated matters, and so I asked him if he would join with me in this. And he was pleased to do so.

Q. Were you aware that Dr. Mayer had been deposed in a court case involving a similar question with regards to this case, which had to do with coverage for gender-affirming care?

A. I'm aware that -- I'm aware that Dr. Mayer

Hopkins could give it, you know. And Johns Hopkins --

Q. If we turn to the next page --

A. Yeah.

Q. -- in the first full question and following answer, it states:

Question: You said that some of his views concern you or bother you. What views are those?

Answer: Well, I don't want to say what he thinks, but he's made statements that I would consider anti-gay, anti-transgender. And sometimes he has strong opinions, but he could influence people more if he wasn't so extreme. People told me he could use words like "gender pretender." Or he's made analogies to anorexia. And I don't think those are very helpful. I also think they can be mean-spirited, quite frankly.

Were you aware of this critique by Dr. Mayer about your views?

A. I'm aware of this critique by many people about my views.

I consider them wrong. I'm not anti-anything. I'm trying to work for the benefit of all patients.

And so they might be right that I could influence people if I wasn't so flat-footed about my opinion, but I believe that somebody in my position as

Which -- Question: Which is Paul McHugh's view?

Answer: Well, I don't know. He's made some extreme statements about tran -- I mean, I read a statement about gender pretenders or something like that, an analogy to -- to body dysmorphic disorder. And kind of -- I believe he might even have said that transgenders are mentally ill. Don't quote me on that, but I believe he has. I find that very bothersome. Very bothersome.

Were you aware of that critique by Dr. Mayer of your views?

A. No, I wasn't. He never expressed it to me, as he says.

Q. Do you believe that being transgender is against God's will?

A. Of course not.

MR. KNEPPER: Form.

Q. We previously looked at an article titled, "Surgical Sex," that you published in "First Things" in 2004.

Do you recall that?

A. I do. Yes.

Q. Who publishes "First Things"?

A. "First Things" is published by -- well, I

don't know the organization behind it. It's a -- it's a Christian organization, and it has a -- it has a Christian background.

MR. GONZALEZ-PAGAN: And Lauren, we can remove the exhibit from screen share.

BY MR. GONZALEZ-PAGAN:

Q. Are you familiar with the Institute on Religion and Public Life?

A. Yes, I am. I should know that.

Q. Is that the publisher of "First Things"?

A. That's right. Yes.

Q. And is "First Things" a peer-reviewed journal?

A. No.

Q. Is it a scientific publication?

A. No. But I'd already published in scientific peer-reviewed journals, so I was now expressing my opinion to the public, as I would in -- if I were writing for "The Atlantic" or "The New Yorker."

MR. GONZALEZ-PAGAN: Lauren, if we could show on the screen what's been marked as Exhibit 13 on the September 8 deposition.

Q. And this is your article in "First Things" titled "Surgical Sex." Is that right, Dr. McHugh?

A. That's correct. Yes. Right.

Q. The first four sentences of the second paragraph read, "Their regular response was to show me their patients. Men (and until recently they were all men) with whom" I'd spoken -- "with whom I spoke before their surgery would tell me that their bodies and sexual identities were at variance. Those I met after surgery would tell me that the surgery and hormone treatments that had made them 'women' had also made them happy and contented. None of these encounters were persuasive, however. The postsurgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness -- but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged)."

Did I read that correctly?

A. Yes, sir. Yes.

Q. Do you believe that transgender women are caricatures of women?

A. They often are, yes.

Q. You begin your article "Surgical Sex," in the first paragraph, by making reference to the "Serenity Prayer." Is that right?

A. Yes, I did. Yes.

Q. Do you believe that religious views should determine whether transgender people diagnosed with gender dysphoria should be able to access gender-affirming care?

A. Excuse me. I didn't understand that question. Give it to me again.

Q. Sure. Do you believe that religious views should determine whether a transgender person diagnosed with gender dysphoria should be able to access gender-affirming care?

A. No, I don't believe religious views, at the moment, should do that. I think somebody's religious views may well influence what they're doing, but in this discussion, I don't think religious views should be the prominent ones.

MR. GONZALEZ-PAGAN: We can stop sharing the exhibit on the screen.

BY MR. GONZALEZ-PAGAN:

Q. We also previously established that you had three other publications relating to gender dysphoria, one being "Psychiatric Misadventures"?

A. Yes.

Q. And that publication was in the early '90s in "The American Scholar." Is that right?

A. Correct. Yes.
Q. And "The American Scholar" is not peer reviewed?
A. No, it's not.
Q. And it's not a scientific publication. Is that right?
A. No, it's not. Yes.
Q. And the other was a commentary piece that you published in "Nature Medicine" in 1995.
A. Yes.
Q. It was not a study, but an essay.
A. Yes.
Q. Is that correct?
A. That's correct.
Q. And the last one was a publication just last month on the publication "Commentary." Is that right?
A. That's right. Yes.
Q. And "Commentary" is not a peer-reviewed publication. Is that right?
A. No, it's not. That's right.
Q. And it's not a scientific publication. Is that right?
A. No. That's correct.
Q. So none of your publications relating to this topic are actually studies. Is that correct?

A. No. I have not published an actual study. Right. I've reviewed studies, but I haven't made a study of my own, no.

Oh, dear. It's okay.

Q. All right. I just -- previewing, I just have like three or four questions, and then I think it may be appropriate to take a break, but I just want to finish my questioning.

A. Sir, you're very welcome.

Just a second. I've lost your screen for some reason or another.

Q. Okay. We can wait. We can wait for you, of course.

A. I think I'm coming back.

There you are. I'm back.

Q. No problem.

A. For some reason or another, my screen automatically shut off.

Okay, sir. Here, I am. Go ahead.

Q. I think we've discussed throughout September 8 and today how you state your concerns are scientific in nature about the provision of this care. Is that right?

A. That's correct.

MR. KNEPPER: Form.

Q. I am wondering, if your concerns are scientific and, purportedly, they date back at least until the mid-'70s -- is that correct?

A. Yes.

Q. Why have you chosen to publish about these matters primarily in nonscientific journals?

A. Because I thought that I could express my opinions there to the public at large. I thought the public at large needed to know that there was great contention in these matters. And although I did, after all, publish in "Nature Medicine," I did publish my opinions also publicly. It seemed that that was my responsibility as the director of the psychiatry department at Johns Hopkins, especially after we had decided that we were not going to support this any longer.

Q. I am curious. If your concerns are also -- in a similar vein, if your concerns are primarily scientific, why did you decide to publish primarily three of the last four publications in the last 20 years in religiously affiliated publications?

A. They were interested in my opinion. They asked me, most of them. They asked me if I would express it.

Q. Have you -- have you sought to have your

views regarding this matter, in the last few years, published in a peer-reviewed journal?

A. I have. In fact, I asked "The New England Journal" if they would be interested in having me write something on a respective. And they decided they didn't wish to have it published -- they didn't wish me to -- they didn't want to commission me to do that. So I tried.

MR. GONZALEZ-PAGAN: I think that we're at a good point to do a break, if that makes -- if that's okay with people.

THE WITNESS: If that is needed. It's not necessary for me. I would really like to press on to the end here, if I could, given that the day -- I don't wish to consume the whole day in this.

MR. GONZALEZ-PAGAN: No. I appreciate that. I'll be honest, I only have a few more pages left. So let's do -- understanding that you'd like to press on, let's do a five-minute break.

THE WITNESS: That would be fine.

THE VIDEOGRAPHER: We'll go off the record at 10:48 a.m.

(Recess taken.)

THE VIDEOGRAPHER: We are back on the record at 10:59 a.m.

general population at large. Is that right?
A. That's correct.
Q. Did you file a brief opposing the ability of transgender students to use the restroom consistent with their gender identity?
A. I did.
Q. Was that in the Gavin Grimm case?
A. Yes. Yes, sir.
Q. In that brief, did you argue that conditioning children into believing that a lifetime of impersonating someone of the opposite sex achievable only from chemical and surgical interventions is a form of child abuse?
A. I did say that. And I believe that.
Q. Is it your view, then, that the provision of gender-affirming care to transgender adolescents is a form of child abuse?
MR. KNEPPER: Object to the form.
A. I believe that's exactly -- I've said that several times.
Q. Do you believe that the Center for Transgender Health at Johns Hopkins is engaging in a form of child abuse?
A. When I talked with them when they were beginning, they said they were not going to do this

treatment to any child, and therefore, I said, that's good. If you don't do it to any child, you won't -- you'll avoid child abuse, as Dr. Lee may well testify to.

I've made no secret of the idea that these -- it's impossible to give informed consent, when you're a child or adolescent, about what is going to be a long-term effect on your body and, fundamentally, your life.

Q. Are you aware that the Johns Hopkins Center for Transgender Health provides gender-affirming hormonal care to adolescents?

A. I have learned that since.

Q. Do you believe, then, that they're engaging in a form of child abuse?

A. Let me -- this is what -- probably thinks about being flat-footed. I'm quite flat-footed about this. I believe that changing the body of adolescents -- children or adolescents before the age of 21 is a form of child abuse. I'm quite -- I'm quite certain about that, about my opinion. Let's put it that way.

This is my opinion, and I've expressed it in several ways. You don't have to change around to find that. I'm terribly against it, as a form of misabuse

of a child -- misuse of a child and their feelings.

Q. And you're aware that no medical or hormonal or surgical treatment is recommended or provided to prepubertal youth? Are you aware of that?

A. There's no -- no -- nothing --

Q. Let me restate that. Are you aware that no hormonal or medical treatment is recommended for prepubertal youth?

A. I'm aware that some people are doing it with children in the early phases of puberty. So I suppose the issue of prepubertal or early pubertal is a useful guideline, but that they're talking about using these treatments before people have fully developed, is my opinion; not only my opinion, it's what they're saying they're doing.

I'm sure the endocrinologists will help you with that better than me.

Q. Do you believe that transgender people are disordered?

A. I believe they suffer from an overvalued idea, yes. I expressed that in my article in "Nature Medicine."

Q. Let me ask you this. Do you -- do you believe that your opinion that the provision of hormonal and surgical care to anyone under 21 for the

ethnic origins or, for that matter, your sex.

Q. All right. Let's return to Exhibit 2 to the September 8 deposition, that being your report, if we can put that up.

A. Good.

Q. If we go to page 13, if we look in the middle there's -- one of your opinions states, "A currently unknown" --

MR. GONZALEZ-PAGAN: You can zoom in towards the middle. Yeah. Yeah, if we can zoom in a little bit for the doctor, that would be great.

THE WITNESS: Yes.

MR. GONZALEZ-PAGAN: Okay. If you go down a little bit, just so it's in the center.

BY MR. GONZALEZ-PAGAN:

Q. It states, "A currently unknown number (but likely larger than 50 percent)" --

A. Just a second.

Yeah, I got it. Okay. Yes.

Q. Did you find it, right in the middle?

A. I did. I've got it, yeah.

Q. Okay. It states, "A currently unknown number (but likely larger than 50 percent) of patients reporting gender dysphoria suffer from psychiatric illness(es) that can complicate and may distort their

judgments and perceptions of gender identity."

Did I read that correctly?

A. You did, sir.

Q. What is the literature that you rely on to back up this statement?

A. The literature in autism and other articles of that sort. As I say, it's currently unknown, just as the literature describes some of the psychological problems these patients are suffering from, some reported by their families.

I think Laura Littman's article, for example, on the rapid onset of gender dysphoria in young girls makes something of this.

Q. This article does not involve any conversations or study with any of the patients allegedly having gender dysphoria. Is that right?

A. No. It has -- it is involved with a discussion with the parents of these -- often the parents of these young children -- young people.

Q. I guess I'm wondering, on what literature do you rely on to say "likely...than 50 percent"?

A. I can't give you an article that would show you that. But the patients that are there, that other people speak about, wonder, you know. What's really happening is that, when I say "a currently unknown

number," it's very often because people are not studying the patients thoroughly enough. That's the reason it's currently unknown. I believe it's larger than 50 percent.

Q. Is there any literature that you can cite to, to --

A. Not at the moment. But I'm certain you could probably find it, if you look.

Q. To what psychiatric illnesses do you refer to in this statement?

A. I'm referring to patients with depression, with major depression, with autism, with some aspects of obsessive compulsive disorder, and things of that sort.

Q. Autism is not a psychiatric illness, though. Right?

A. No. It is a psychiatric disorder. Yes, it is. Autism is. Of course, it is.

Q. Is there any literature that you can point to, to back up your statement that depression distorts a person's judgment and perception of gender identity?

A. Of course, I can. Many -- many people with depression have disordered attitudes about their world, including committing suicide.

Q. But, like, is there any literature that you

can point to, specifically, with regards to how depression distorts a person's judgment and perception of their gender identity?

A. It distorts judgments and perceptions about everything in its life. And if he or she is in a community where gender identity is a problem, it turns up there.

Q. Okay. Is there any literature that you can point us to that, any examples you can give us?

A. I'm certain it could be found, but I haven't -- I can't point to one right at the moment, no.

Q. Okay. Same question with regards to anxiety. Any literature you can point to?

A. No. I cannot. No, I can't point to any particular literature.

Q. Would you agree that there are some patients with gender dysphoria who do not have other cooccurring mental health diagnoses?

A. I can't -- I can't affirm to that because I don't believe that many people study their patients thoroughly enough to make sure there are not other things in their mind, some aspects of their life story, some aspects of their sexual abuse as children. Many have reported, later on, about sexual abuse. These are the kinds of things which produce psychiatric problems

for which gender identity sometimes is a problem.

Q. Is it your opinion that every person who is transgendered, therefore, has another psychiatric illness?

A. No. It is my opinion that everybody who has a gender dysphoria suffers from an overvalued idea. That's what they have. And that overvalued idea often will derive from some psychiatric problem, a psychiatric problem expressed in diagnostic terms, like depression, but may well be expressed -- may be the expression of some abuse or mistreatment that they had earlier in their life. But all of them suffer from an overvalued idea in my opinion.

Q. And that overvalued idea, does it always come from a psychiatric illness?

A. Well, you have to understand what I mean by psychiatric illness. I mean a disturbance of psychiatrics, of a psychological kind. And that may come out of a life experience, as does grief, posttraumatic stress disorder, things of that sort. It may come out of a personality type, like obsessive compulsive disorder. It may come out of a disorder and illness like depression, but it may come out as simply a behavior -- another form of behavior that encourages gender identity questions.

Q. I guess what I'm asking is, can gender dysphoria exist independent of whether somebody else has a psychiatric illness or experience that leads to this overvalued issue?

A. I don't know the answer to that because I don't think it's being studied properly to decide whether gender dysphoria is an independent event or whether it, in some way, comes out of some misadventure, psychological misadventure.

To some extent, that's why it's so contentious at the moment, because we're not studying it thoroughly. We've committed ourselves to a particular therapy without really studying it adequately.

Q. If you go to the next bullet point, the next opinion, it states, "A currently unknown percentage and number of patients - many of them adolescent females - reporting gender dysphoria have been heavily influenced and/or manipulated by a source of social contagion - peer group, social media, YouTube influencers, therapists, and/or parents."

Can you cite to any scientific study that show that gender dysphoria is caused by social contagion?

A. Yes, I can point -- of course, Laura Littman,

she was the one who made it -- made this most clearly.

But you know, social contagion, it would be very strange if it didn't have some role here since the discussions by and studies of Nicholas Christakis and other people show social contagion to be an important aspect of all kinds of human behaviors.

As I said, since I believe that gender dysphoria is an expression of a behavior, social contagion must be a role -- must be playing a role. And you go, now, onto social media, and you see that people whose backgrounds and whose attitudes -- and they have no idea about it -- are speaking in groups to young people.

Q. Well, would it be fair to say, then, that your statement here is, at best, a hypothesis and not a statement of fact?

MR. KNEPPER: Object to form.

A. Excuse me. I didn't hear that, Counselor. Give it to me --

Q. Would it be fair to characterize your opinion here as a hypothesis and not a statement of fact?

A. It is a hypothesis, yes.

Q. Okay. And aside from the Littman article, which we established does not study the actual patients with gender dysphoria, can you cite to any scientific

study that shows that gender dysphoria is caused by social contagion?

A. At the moment, I can't point out to any -- any particular one. But many -- many students of the social media today are making this point themselves.

Q. In your report, you make reference to national reviews --

MR. GONZALEZ-PAGAN: And we can go to page 10, Lauren, if we could.

THE WITNESS: Sure.

BY MR. GONZALEZ-PAGAN:

Q. And the last paragraph there on page 10.

You make reference to "national research reviews in England, Sweden, and Finland." Do you see that?

A. Yes, I do. Yeah.

MR. GONZALEZ-PAGAN: We can -- we can stop sharing the screen, Lauren.

Q. What is the national review from England to which you refer?

A. There was these various studies that -- there have been a number of studies, both in Britain and in Sweden and in Finland, that have been reviewed in the legal documents. And I can't put my finger on it for you right now. I'm sure we could find it.

Q. Do you know whether it was peer reviewed?
A. I'm sure it would be.
Q. Would it surprise you if I told you that it wasn't?
A. Well, it would not surprise me, but it would -- it would encourage me to tell you that it hasn't been refuted either. But peer reviewed --
Q. Do you know if it was published in a scientific journal?
A. I don't.
MR. KNEPPER: Objection. Form.
Q. What is the national review from Sweden to which you refer?
A. I was referring to the Dhejne one that we mentioned before.
Q. Is it the study from 2011?
A. Yes.
Q. This is not a national review study. This is an academic scientific study. Is that right?
A. It is a scientific study, yes.
Q. And we established that it was just simply comparing the rate of suicidality between postop people with gender dysphoria and the general population at large. Is that right?
A. Yes, we did.

Q. What is the national review from Finland to which you refer?

A. I can't put my finger on it for you right now, but Finland is, as I understand it, because of these things, looking much more carefully at the treatments. I can't point these things out to you right at the moment. Not at my fingertips.

Q. Yeah. I mean, I guess my question, in part, has to do with, I may have an idea, maybe, of what you're talking about.

A. Good.

Q. But I don't know to what you're referring to in your report, and there's no bibliography. So I'm asking those questions now --

A. That's fair enough.

Q. -- because I don't know to what studies you are referring to.

A. That's fair enough. I think we can find them if we need to.

Q. Do you know whether the review -- the national research review from Finland to which you refer was published in a scientific journal?

A. No. I'm not sure.

Q. Do you know whether it was peer reviewed?

A. I'm not sure. It probably was.

Q. Would you be surprised if I told you that it wasn't?

A. Nothing would surprise me right now because this is a contentious issue and a contentious matter, and so the fact that you say, well, the peers not reviewing it, yeah, that will happen.

Most of the evidence now is moving in the direction that I'm saying.

Q. Are you aware that the review in Finland pertained solely to the care for minors or adolescents?

A. Yes, I am. I was aware of that.

Q. Are you aware that the report --

Yeah. Go ahead.

A. That's the issue, isn't it, the minors? Yeah.

Q. Well, you say, "That's the issue." And so I guess I want to ask, this care pertains to a categorical exclusion that prohibits medical care not just for adolescents but also for adults.

A. I understand that. I was just saying, this is the issue in Finland, isn't it? That's what I meant.

Q. Are you aware that the report from Finland recommends that hormonal intervention may be considered before reaching adulthood in those with firmly

established transgender identity?

A. I was aware of that, yes.

Q. Do you disclose in your report that Finland does provide coverage for hormonal and medical treatment for gender dysphoria in adolescents and adults?

MR. KNEPPER: Objection. Form.

A. I don't -- I don't understand the question quite there.

Q. Sure. You speak of this review -- national research reviews as casting doubt on the propriety of this treatment.

Is that a fair characterization?

A. That's fair, casting doubt, yes.

Q. And I guess an important limitation to that is that, in these countries, which have nationalized healthcare systems --

A. Yeah.

Q. -- they provide and cover this care.

A. Yes. Yes. But they're doubting it, and the chances -- what I'm saying, I suppose, here -- what I mean to imply is that the movement is towards more and more doubt of this, what was once a confident opinion of treatment and --

Q. Do you think it is any -- do you think it is

a limitation of your opinion and a valid -- it would have been helpful to the Court for you to disclose that, notwithstanding this doubt, the healthcare system in these countries still provide for and cover for this care?

MR. KNEPPER: Objection.

A. No, I don't think so. I was making a point.

Q. Last time, on September 8, when we were talking, you stated that, quote, "I think people do better and live better and flourish better and need less help from...doctors if their natal sex and their attitude towards...their own sex is the same."

A. Yes.

Q. Okay. So that sounds like -- do you stand by that statement today?

A. I do.

Q. On what peer-reviewed or scientific literature do you rely on for that opinion?

A. This -- this is -- I'm relying on, primarily, common sense, having -- seeing nothing on the opposite that would prove me wrong.

Q. But as we stand here today, is there any scientific literature or article or study that you can point to, that supports that opinion?

A. What I'm saying is that, this is my opinion.

If you wish to change my opinion, you need a scientific article that proves my opinion to be wrong.

I know no article that proves my opinion to be wrong. I'm not saying that my opinion will be supported, but I'm saying that, when you make such a contention that somebody's sex would do -- somebody would do better by trying to change what is impossible to change and to live in that way, that that will be the long-term benefit of the patient, I think the problem of the proof is with you, not with me.

Q. You are aware, however, that there are cohorts and cross-sectional studies that do demonstrate benefit to the transgender patients' --

A. I'm aware of them. I also --

Q. -- medical treatment?

A. I beg your pardon. I didn't mean to interrupt you.

Q. No.

-- that complete medical treatment.

A. Yeah, I'm aware of them. I'm also aware of their limitations, that they're not long enough and that many professional organizations agree, even when they -- when they support it, that the evidence is yet not strong.

MR. GONZALEZ-PAGAN: All right. I know we've

EXHIBIT C

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Case No.: 1:19-cv-272-LCB-LPA

MAXWELL KADEL, et al.,	)
	)
Plaintiffs;	)
v.	)
	)
DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, et al,	)
	)
Defendants.	)

Expert Witness Declaration of
Paul R. McHugh, MD
Baltimore, Maryland 21218

Knowledge Training and Experience :

1. **Education and Training - Retention - Compensation :** After graduating from Phillips Academy, Andover, in 1948, I received an A.B. degree from Harvard College in 1952 and an MD degree from Harvard Medical School in 1956. I completed my medical internship at the Peter Bent Brigham Hospital Boston, Massachusetts (1956-57) , my residency in neurology at the Massachusetts General Hospital (1957-60) and a Neuropathology Fellowship at the Massachusetts General Hospital (1958-59). I served as a Clinical Assistant in Psychiatry at the Maudsley Hospital, London, England (1960-61) with additional training as a Member of the Neuropsychiatry Division Walter Reed Army Institute of Research, Washington, D.C. (1961-64). My professional background, experience, and publications are further detailed in the updated copy of my curriculum vitae attached as Exhibit A to this declaration. I was retained as an expert

in this case by Attorney John Knepper. I have reviewed the case Complaint and Answer and will receive no compensation for my analysis-report-testimony in this matter.

2. **Board Certifications, License History, and Practice of Medicine :** I was qualified in both Psychiatry and Neurology by the American Board of Psychiatry and Neurology. National Board of Medical Examiners, Certified #35725; American Board of Psychiatry and Neurology, Certified #9508 ; Massachusetts Registration #26021 ; New York Registration #93799 ; Oregon Registration #8693 ; Maryland Registration #D-18666

3. **Medical Staff and Faculty Appointments :** I served as Asst. Professor, then Associate Professor, then Full Professor of Psychiatry at Cornell University Medical College (1964-1971). I also served as the Founder and First Director of Bourne Behavioral Research Laboratory, Westchester Division of the New York Hospital, Department of Psychiatry, Cornell Medical College (1967-68). I then served as Professor and Chairman: Department of Psychiatry at the University of Oregon Health Sciences Center (1973-75). From 1975 to 2001, I served as the Henry Phipps Professor of Psychiatry and the director of the Department of Psychiatry and Behavioral Science at the Johns Hopkins University School of Medicine. During this time period, I also served as the psychiatrist-in-chief at the Johns Hopkins Hospital and Professor in Department of The Johns Hopkins School of Hygiene and Public Health, Mental Health (1975 -). I also served as the Chairman of the Medical Board of the The Johns Hopkins Hospital, 1984-89. I continue to serve as the University Distinguished Service Professor of Psychiatry at Johns Hopkins University School of Medicine (1998 -).

4. **Publications and Editorial Work:** I have published many peer reviewed articles in scientific journals. (See attached Curriculum Vitae). I have also published a number of books including :

Author:

McHugh, P. R. (2006). Try to Remember: Psychiatry's Clash over Meaning, Memory, and Mind. New York: DANA

McHugh, P.R. (2008). The Mind Has Mountains: Reflections on Society and Psychiatry. Baltimore, MD: Johns Hopkins University Press.

Co-author:

— Hedblom, J. H., & McHugh, P. R. (2007). *Last Call: Alcoholism and Recovery*

— Fagan, P. J., & McHugh, P. R. Sexual Disorders: Perspectives on Diagnosis and Treatment.

— Neubauer, D. N., & McHugh, P. R. Understanding Sleeplessness: Perspectives on Insomnia.

— McHugh, P. R., & Slavney, P. R. (1998). *The Perspectives of Psychiatry,* 2nd ed. Baltimore, Maryland: Johns Hopkins University Press.

Editor:

— McHugh, P. R., & McKusick. Eds. (1990). *Genes, Brain, and Behavior.The Perspectives of Psychiatry (*1983 with Phillip R. Slavney)

I also served as an Editor or Reviewer for the following Journals:

Editorial Positions: 1. Associate Editor for the American Journal of Physiology: Regulatory, Integrative and Comparative Physiology, 1982 - 1996; President, Association for

Research in Nervous and Mental Disease (ARNMD), December 1989, "Genes, Brain and Behavior"

Editorial Boards: The Journal of Nervous and Mental Disease, Comprehensive Psychiatry, Medicine, Psychological Medicine, The Johns Hopkins University Press, International Review of Psychiatry, The American Scholar

Book Service Editorial Boards: The Handbook of Psychiatry, Cambridge University Press ; The Scientific Basis of Psychiatry, Cambridge University Press; Brill's Studies in Epistemology, Psychology and Psychiatry ; The Handbook of Behavioral Neurobiology; and The Johns Hopkins Series in Contemporary Medicine and Public Health.

5. **Awards :** In 1992, I was elected to the Institute of Medicine (IOM) - National Academies of Science (now known as the National Academy of Medicine). In 2001, I was appointed by President George W. Bush to the President's Council on Bioethics. I have received a number of Fellowships including those from the American College of Physicians, the American College of Psychiatrists, the American Psychiatric Association, and the Royal College of Psychiatrists. Other awards include:

William C. Menninger Award, American College of Physicians, 1987.

The Distinguished Achievement Award, The New York Hospital-Cornell Med. Center, Ctr. Alumni Council, 1988.

The Johns Hopkins University Alumni Association Excellence in Teaching Award, 1992.

Joseph Zubin Award of the American Psychopathological Association, 1995.

Distinguished Service Award, The American College of Psychiatrists, 2002.

Visiting Scholar, The Phi Beta Kappa Society, 2003-2004.

Distinguished Life Fellow, American Psychiatric Association, 2003.

Paul Hoch Award of the American Psychopathological Association , 2006.

Rhoda and Bernard Sarnat International Award in Mental Health of the Institute of Medicine, 2008.

Distinguished Career Award. Society for the Study of Ingestive Behavior, 2009.

Doctor Honoris Causa. University of Zaragoza, Spain, 2012.

6. Research Grants : Principal Investigator for research grants from the National Institutes of Health: A. Hormonal Studies in Depression. 1964 - 1968 ; B. Establishment of a primate research resource. 1967 - 1970 ; C. Hypothalamic studies in endocrinology. 1970 - 1974 ; D. #R01AM18554 Hypothalamus in Feeding Behavior. 1975- 1985 ; E. #R01AM19302 Gastrointestinal Integration and Feeding. 1985-95. (Became Co Principal Investigator in 1989, T.H. Moran became Principal Investigator). (See attached Curriculum Vitae).

7. **Psychiatric Misadventures *:*** In 1992, I published McHugh, P.R. *Psychiatric Misadventures*. The American Scholar, 61:497-510, 1992. This essay was selected and reprinted in The Best American Essays, 1993. ed. R. Atwan, Publisher, Ticknor & Fields, New York. An important part of my career has been engaged in observing and warning the public and mental health professions about Psychiatric Misadventures. I think this scientific, clinical, and health care system history will be helpful to the court in the Kadel v. Folwell case.

8. **The Psychiatric Misadventure of Lobotomies - a Tragic Psychiatric Misadventure that Damaged Tens of Thousands of Patients, Robbing Them of Their Emotions and Personality:**

A lobotomy, or leucotomy, is a form of psychosurgery, a neurosurgical treatment for mental disorders that involves severing severing prefrontal cortex connections in the patient's brain. The peak of the lobotomy era was earlier than my training, teaching, and practice but I learned much from the history of this bio-medical disaster. This "treatment" — received much attention, endorsement, and even awards as neurologist Antonioa Egas Moniz, shared the Nobel

Prize for Physiology or Medicine in 1949 for the "discovery of the therapeutic value of leucotomy in certain psychoses". By 1951, nearly 20,000 lobotomies had reportedly been performed in the United States and proportionally more in the United Kingdom. British psychiatrist Maurice Partridge, who conducted a follow-up study of 300 patients, reported that the treatment achieved its effects by "reducing the complexity of psychic life". Following the operation, "spontaneity, responsiveness, self-awareness, and self-control were reduced. The activity was replaced by inertia, and people were left emotionally blunted and restricted in their intellectual range." Many of these patients were left with with severe and disabling impairments. Proper informed consent was not obtained for these experimental "treatments". Surgeon Walter Freedman, who used the procedure widely, coined the term "surgically induced childhood" to refer to the results of lobotomy. [See, e.g., Partridge, Maurice. *Pre-frontal leucotomy:*. Oxford: Blackwell Scientific Publications; 1950.] Currently, the lobotomy era is viewed as an unethical psychiatric misadventure and an assault on the rights, health, and personalities of vulnerable patients. Like the infamous Tuskeegee research, and the horrific experiments of the Nazis and Imperial Japan in WWII, lobotomies are a textbook example of why informed consent protections are vital for patient safety and dignity.

7. **Early Warnings about the Methodological Limitations of a Psychiatric Dictionary — the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association — a Psychiatric Misadventure of Assessment and Diagnosis:**

In 1997, I testified in the *Rhode Island vs. Quattrochi* case Daubert hearing that the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) was essentially a dictionary based on consensus-seeking voting methodologies rather

than evidence-seeking scientific methodologies. [See, Grove, W. M. and Barden, R.C. (2000) Protecting the Integrity of the Legal System : The Admissibility of Testimony from Mental Health Experts Under Daubert/Kumho Analyses, Psychology, Public Policy and Law, Vol 5, No. 1, 234-242.] In 2012, I published an essay in *The New England Journal of Medicine* (with co-author Phillip R. Slavney) seeking reforms to the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association which was soon to be published in its fifth edition. One of our main criticisms contended that the DSM used a top-down checklist approach to diagnosis rather than a thorough bottom-up approach. We compared the DSM to a field guide used by amateur birders to identify birds. It is important for legal professionals to understand that the DSM was created using a consensual, political process of committees and voting methodologies. Voting by committees is not a reliable-valid scientific, evidence-based process. The DSM was thus not built using uniformly valid and reliable scientific processes. In the DSM methodology, small groups of professionals, some with ideological or personal agendas, would form committees and create diagnoses to be "voted" into the DSM. The field has increasingly come to see the DSM as controversial and in need of reforms.

The limitations of the DSM methodology are now well known leading to calls for corrections from the relevant scientific community. See, e.g., Lee, C., *The NIMH Withdraws Support for DSM-5: The latest development is a humiliating blow to the APA*. Psychology Today News Blog at https://www.psychologytoday.com/us/blog/side-effects/201305/the-nimh-withdraws-support-dsm-5 ["Just two weeks before DSM-5 is due to appear, the National Institute of Mental Health, the world's largest funding agency for research into mental health, has indicated that it is withdrawing support for the APA's manual. In a humiliating blow to the

American Psychiatric Association, Thomas R. Insel, M.D., Director of the NIMH, made clear the agency would no longer fund research projects that rely exclusively on DSM criteria. Henceforth, the NIMH, which had thrown its weight and funding behind earlier editions of the manual, would be reorienting its research away from DSM categories."] ; See, also U.S. National Institute of Mental Health Director Thomas Insel on Transforming Diagnosis, April 29, 2013, See, https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml "Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment. Patients with mental disorders deserve better. NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system."] In my opinion, the view that the DSM is insufficiently reliable and in need of methodological reforms is generally accepted by the relevant scientific community.

The unreliability of the DSM assessment process is important to understanding defects in transgender treatment methodologies. Patients are diagnosed with a DSM checklist for "gender dysphoria" and sent down a road towards potential sterility or other damages to normal, healthy organs based solely on unverified patient reports and the DSM checklist process. This inherently

unreliable process may explain in part why research in this field indicates an ongoing lack of understanding of how to help these vulnerable, suffering patients.

8. **Early Warnings to Protect Patients from the Predicted Iatrogenic Damages of the "Repressed Memory Therapy" and "Multiple Personality Disorder" Industries — a Psychiatric Misadventure that damaged tens of thousands of patients and families:**

In the early 1990s, I took the — very unpopular at the time — public position that "repressed childhood memories of trauma" , "recovered memory therapy" (RMT), and "multiple personality disorder" (MPD) were psychiatric misadventures employing unreliable, unscientific notions and methods that posed dangers to patients and to the integrity of the mental health system. See, McHugh, P.R., *Psychiatric Misadventures*, The American scholar, January 1993 ; McHugh, P.R. Resolved: Multiple Personality Disorder is an Individually and Socially Created Artifact. J. of the Amer. Academy of Child and Adolescent Psychiatry, 34:7 1995; McHugh, P.R. Witches, multiple personalties, and other psychiatric artifacts. Nature Medicine, 1:2 110-114, 1995 ; and McHugh, P.R. Multiple Personality Disorder—A Socially Constructed Artifact. J. of Practical Psychiatry and Behavioral Health, 1:3 158-166, 1995. By the end of the 1990s, after many dozens of research studies, dozens of civil malpractice lawsuits against "recovered memory" and "MPD" therapists, the closing of several RMT-MPD clinics, multiple media exposes, and several licensing revocations of RMT-MPD industry leaders, these treatments largely collapsed saving tens of thousands of patients and families from harm.

It is now well documented that the RMT-MPD misadventure was perhaps the worst disaster to befall the mental health system since lobotomies. See Pendergrast, M. (2017). *The repressed memory epidemic: How it happened and what we need to learn from it.* New York, NY: Springer ; See also, Barden RC: *Reforming the Mental Health System: Coordinated,*

Multidisciplinary Actions Ended "Recovered Memory" Treatments and Brought Informed Consent to Psychotherapy. Psychiatric Times. 2014;31(6): June 6, 2014. In sum, the field has come to agree that the RMT-MPD industries were indeed another Psychiatric Misadventure.

9. Early Warnings have not been Used to Protect Patients from the Documented Methodological Errors and Predicted Iatrogenic Damages of the Transgender Treatment Industry - yet another Psychiatric Misadventure :

Many years ago, our clinical experiences and research at Johns Hopkins led to the closing of the transgender clinic. Research showed insufficient benefits for the risks involved in such experimental, unproven treatments on vulnerable patients. Like lobotomies, the RMT-MPD industries, and over-reliance on the DSM, the Transgender Treatment Industry is a Psychiatric Misadventure based upon failures to apply proper scientific methodologies and patient protections. The DSM, the RMT-MPD industries and the Transgender Treatment Industries are all examples of failures to avoid confirmation bias, that is failures to properly generate and rigorously test alternative hypotheses without regard for ideological preconceptions. The key motivation of a psychiatrist and all physicians should be to develop, scientifically validate, and then apply the very best and most effective treatments to relieve the suffering of patients — not rapidly apply untested but "politically correct" treatments.

In recent years, this controversial field has faced increasing scrutiny as national research reviews in England, Sweden, and Finland as well a Cochrane Review and studies by multiple researchers have concluded that the evidentiary base for these experimental treatments is weak and demonstrates few benefits or actually shows this procedures can cause more harm than good. The rapid expansion in the number of patients and the rapid demographic shift in patients demonstrate how little we know about these troubles. Faced with overwhelming life problems

and chronic psychiatric illness, some patients seek a simple solution for their suffering. Whether its "recovered memories", "multiple personalities" or "transgender transitioning" such patient can pin their hopes upon this newly ascribed solution to complex life problems. This enormous increase in cases in the US and Europe cannot be explained and was not predicted by the movement's genetic, biological, "brain structure" or "immutable" theories of the etiology of gender discordance.

In contrast, the exponential growth in patients was indeed predicted and is readily explained by a social contagion theory — the same process by which adopting repressed memories and multiple personalities came to damage so many tens of thousands of lives. See, Hruz, PW, Mayer, LS, and McHugh, PR, "Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria," The New Atlantis, Number 52, Spring 2017 pp. 3 -36; See also, Van Mol, A., Laidlaw, M. K., Grossman, M., McHugh, P. , Gender-Affirmation Surgery Conclusion Lacks Evidence, Am J Psychiatry 177:8, August 2020 ajp.psychiatryonline.org 765.

10. **The Transgender Treatment Industry Has Come Under Increasing Criticism In Recent Years as Methodological Errors and Systemic Failures have been publicly aired and debated including: (See Detailed Notes and Research-Review Citations attached).**

A) Current transgender theories failed to predict the widely reported exponential increase in cases (i.e. this is clearly not due to genetics, "brain structures", or "immutability"… social contagion seems more likely).

B) Current transgender theories failed to predict the rapid and unusual changes in patient demographics (from young boys with early onset-chronic dysphoria to adolescent females with rapid onset of gender dysphoria symptoms.

C) The Transgender Treatment Industry has failed to conduct competent randomized clinical trials to assess the safety and effectiveness of treatments despite offering "treatments" for 50 years.

D) The Transgender Treatment Industry has failed to conduct competent, rigorous long-term treatment outcome research despite having 50 years to do so.

E) The Transgender Treatment Industry has failed to conduct competent research on the social contagion theory in an attempt to understand the rapid increase in patients and demographic shift — in fact, they tried to suppress such research. This is true even though psychiatry has known for many years that some psychiatric disorders can be influenced by the peer group dynamics of adolescent girls. (e.g., eating disorders). See, e.g. L. Littman (2018), Parent Reports of Adolescents & Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria, PLoS ONE 13(8): e0202330.

F) The Transgender Treatment Industry has failed to properly and fully inform patients and the public of the serious risks, dangers, controversies, and methodological shortcomings of the current experimental treatments offered.

G) The Transgender Treatment Industry has tragically failed to acknowledge and properly learn from and adapt to the valid criticisms. The industry has yet to admit and advance beyond its scientific and clinician flaws, errors, and mistakes. Until it does, it will continue on as an example of a Psychiatric Misadventure.

11. **SUMMARY OPINIONS:** It is my opinion, to a reasonable degree of medical certainty that:

— There are currently no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are ***helped*** by such procedures.

— There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are ***injured or harmed*** by such procedures.

— There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the reliability and validity of *assessing* gender identity by relying solely upon the unverified statements of a patient.

— A currently unknown number (but likely larger than 50%) of patients reporting gender dysphoria suffer from psychiatric illness(es) that can complicate and may distort their judgments and perceptions of gender identity.

— A currently unknown percentage and number of patients — many of them adolescent females — reporting gender dysphoria have been heavily influenced and/or manipulated by a source of social contagion — peer group, social media, YouTube influencers, therapists, and/or parents. Detailed psycho-social investigations of such patients — sometimes over a period of years — may be necessary to better understand the psychiatric-psychological-and neurological complexities of reported gender discordance.

— Patients suffering from gender dysphoria or related issues ***have a right to be protected*** from experimental, potentially harmful treatments lacking reliable and valid, peer reviewed, published, long-term scientific evidence of safety and effectiveness.

— Multiple research studies have shown that a large percentage of children (over 80% in some studies) who initially reported gender discordance will, ***if simply left alone***, develop a natural acceptance of their natal (biological) sex. Halting this natural healing process with hormones or surgery — when there are no reliable ways to predict which children will heal on their own — is an improper and experimental process that will produce lasting damage to many children.

— Medical treatments may differ significantly by sex according to chromosomal assessment but not by gender identity. ***Misinforming physicians of a patient's biological sex*** can have deleterious effects on treatment for a variety of medical conditions.

— Affirmation ("transgender transitioning") medical treatments — hormones and surgery — for gender dysphoria and "transitioning" remain unproven and have thus ***not been accepted by the relevant scientific communities*** (biology, genetics, neonatolgy, medicine, psychiatry, psychology, etc).

— Affirmation ("transgender transitioning") medical treatments — hormones and surgery — for gender dysphoria and "transitioning" remain unproven and poorly researched and thus ***have no known, peer reviewed and published error rates*** — these treatments methods lack demonstrated, reliable and valid error rates.

— Professional and political associations WPATH, the American Medical Association, the American Academy of Pediatrics, the American Endocrine Society, etc. are **not** the relevant scientific community, they are organizations that rely upon consensus-seeking methodologies including voting rather than careful, prudent, evidence-based, Popperian-testable scientific methodologies.

12. LIMITATIONS ON EXPERT WITNESS REPORTS: - RETENTION - COMPENSATION: My opinions and hypotheses in this matter are — as all expert reports — subject to the limitations of documentary and related evidence, the impossibility of absolute predictions, as well as the limitations of social, biological, and medical science. I have not met with, nor personally interviewed, anyone in this case. As always, I have no expert opinions regarding the veracity of witnesses in this case. I have not yet reviewed all of the evidence in this case and my opinions are subject to change at any time as new information becomes available to me. Only the trier of fact can determine the credibility of witnesses and how scientific research may or may not be related to the specific facts of any particular case. In my opinion, a key role of an expert witness is to help the court, lawyers, parties, and the public understand and apply reliable scientific, technical, and investigative principles, hypotheses, methods, and information. I have transmitted this confidential expert report directly to Attorney John Knepper (john@knepperllc.com) for distribution as consistent with the laws of the appropriate jurisdiction for this case.

Pursuant to 28 U.S.C § 1746, I declare under penalty of perjury under the laws of the United States of America that my foregoing report in the Kadel v. Folwell case is true and correct.

Signed: _____ Date: _____
Paul R. McHugh, MD

12. LIMITATIONS ON EXPERT WITNESS REPORTS: My opinions and hypotheses in this matter are — as all expert reports — subject to the limitations of documentary and related evidence, the impossibility of absolute predictions, as well as the limitations of social, biological, and medical science. I have not met with, nor personally interviewed, anyone in this case. As always, I have no expert opinions regarding the veracity of witnesses in this case. I have not yet reviewed all of the evidence in this case and my opinions are subject to change at any time as new information becomes available to me. Only the trier of fact can determine the credibility of witnesses and how scientific research may or may not be related to the specific facts of any particular case. In my opinion, a key role of an expert witness is to help the court, lawyers, parties, and the public understand and apply reliable scientific, technical, and investigative principles, hypotheses, methods, and information. I have transmitted this confidential expert report directly to John Knepper (john@knepperllc.com), for distribution as consistent with the laws of the appropriate jurisdiction for this case.

Pursuant to 28 U.S.C § 1746, I declare under penalty of perjury under the laws of the United States of America that my foregoing report in the Kadel v. Folwell case is true and correct.

Signed: Paul R. McHugh **Date:** 5/1/21

Paul R. McHugh, MD

Exhibit A

Curriculum Vitae

PAUL R. McHUGH, M.D.

Home address:	3707 St. Paul Street Baltimore, Maryland 21218
Born:	May 21, 1931
Place of Birth:	Lawrence, Massachusetts
Marital Status:	Married: Wife's name Jean, 3 children
Schooling:	Phillips Academy, Andover, 1948 Harvard College, A.B., 1952 Harvard Medical School, M.D., 1956
Medical Internship:	Peter Bent Brigham Hospital Boston, Massachusetts (1956-57)
Neurology Residency:	Massachusetts General Hospital (1957-60)
Neuropathology Fellow:	Massachusetts General Hospital (1958-59)
Teaching Fellow in Neurology and Neuropathology:	Harvard Medical School (1957-60)
Clinical Assistant in Psychiatry:	Maudsley Hospital, London, England (1960-61)
Member Neuropsychiatry Division:	Walter Reed Army Institute of Research, Washington, D.C. (1961-64)
Assistant Professor of Psychiatry and of Neurology:	Cornell University Medical College (1964-68)
Associate Professor of Psychiatry and of Neurology:	Cornell University Medical College (1968-71)
Professor of Psychiatry and of Neurology:	Cornell University Medical College (1971)
Director of Electroencephalo-graphy:	The New York Hospital (1964-68)

Founder and First Director:	Bourne Behavioral Research Laboratory, Westchester Division of the New York Hospital, Department of Psychiatry, Cornell Medical College (1967-68)
Clinical Director and Supervisor of Psychiatric Education:	Westchester Division of the New York Hospital, Department of Psychiatry (1968-73)
Professor and Chairman:	Department of Psychiatry University of Oregon Health Sciences Center (1973-75)
Henry Phipps Professor of Psychiatry and Director:	Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine, 1975 - 2001
Psychiatrist-in-Chief:	The Johns Hopkins Hospital, 1975 - 2001
Professor in Department of Mental Health:	The Johns Hopkins School of Hygiene and Public Health, 1975 -
Director: Blades Center for Clinical Practice and Research in Alcoholism	The Johns Hopkins Medical Institutions, 1992 -2001
University Distinguished Service Professor of Psychiatry	The Johns Hopkins University, 1998 -

Qualified in both Psychiatry and Neurology by the American Board of Psychiatry and Neurology.
National Board of Medical Examiners, Certified #35725
American Board of Psychiatry and Neurology, Certified #9508
Massachusetts Registration #26021
New York Registration #93799
Oregon Registration #8693
Maryland Registration #D-18666

<u>Selective Administrative Responsibilities</u>

Chairman of the Associate Professor Promotions Committee:	The Johns Hopkins University School of Medicine, 1978-84
Chairman of the Medical Board:	The Johns Hopkins Hospital, 1984-89

Chairman of the Professorial Promotions Committee:	The Johns Hopkins University School of Medicine, 1985 - 1991
Member of Management Advisory Committee:	The Johns Hopkins Health System, 1989 - 1996
Board of Trustees/Advisors:	The Kennedy Krieger Research Institute, Inc., 1993 - 2001 The Johns Hopkins Hospital (ex-officio), 1984 – 1989 Association for Research in Nervous and Mental Disease, 1987 - The College of Notre Dame of Maryland, 1999 – 2005 False Memory Syndrome Foundation, 1993 – President, Johns Hopkins Chapter, Phi Beta Kappa, 2001 - 2002 President's Council on Bioethics, 2001 – 2008 United States Conference of Catholic Bishops National Review Board, 2002 - 2007
Fellowships:	American College of Physicians American College of Psychiatrists American Psychiatric Association Royal College of Psychiatrists
Memberships:	Alpha Omega Alpha American Academy of Clinical Psychiatrists American Association of Chairmen of Departments of Psychiatry American College of Neuropsychopharmacology American Medical Association American Neurological Association American Physiological Society Association for Research in Nervous and Mental Disease Baltimore City Medical Society Eastern Psychological Association Harvey Society International Society of Psychoneuroendocrinology Maryland Psychiatric Society Medical and Chirurgical Faculty of the State of Maryland New York Academy of Sciences Order of Malta Phi Beta Kappa The Pavlovian Society The Peripatetic Club Sigma XI Society of Biological Psychiatry Society for Neuroscience

Research Advisory Groups:	Bio-Psychology Study Section, NIH, 1985 - 86 Chairman, Bio-Psychology Study Section, 1986 - 89 American Federation for Aging Research (AFAR) Scientific Council of NARSAD (National Alliance for Research on Schizophrenia and Depression, 1986 - Scientific and Professional Advisory Board of FMS (False Memory Syndrome) Foundation, 1992 - Co-Chairman, Ethics Committee of American College of Neuropsychopharmacology (ACNP), 2001 - 2003
Editorial Positions:	1. Associate Editor *American Journal of Physiology* Regulatory, Integrative and Comparative Physiology, 1982 - 1996 2. President, Association for Research in Nervous and Mental Disease (ARNMD), December 1989, "Genes, Brain and Behavior"
Editorial Boards:	The Journal of Nervous and Mental Disease *Comprehensive Psychiatry* *Medicine* *Psychological Medicine* The Johns Hopkins University Press *International Review of Psychiatry* *The American Scholar*
Book Service Editorial Boards:	*The Handbook of Psychiatry*, Cambridge University Press *The Scientific Basis of Psychiatry*, Cambridge University Press *Brill's Studies in Epistemology, Psychology and Psychiatry* *Handbook of Behavioral Neurobiology* *The Johns Hopkins Series in Contemporary Medicine and Public Health*
Grants:	Principal Investigator from the United States Public Health Service, N.I.H. Training: 1. NIH Clinical Traineeship 1960 - 1963 2. Interdisciplinary Training Program in Psychiatry and Neuroscience (Director) 1990 – 1996

Principal Investigator for research grants from the National Institutes of Health:

1. Hormonal Studies in Depression. 1964 - 1968
2. Establishment of a primate research resource. 1967 - 1970
3. Hypothalamic studies in endocrinology. 1970 - 1974
4. #R01AM18554 Hypothalamus in Feeding Behavior. 1975-1985.
5. #R01AM19302 Gastrointestinal Integration and Feeding. 1985-95. (Became Co-Principal Investigator in 1989, T.H. Moran became Principal Investigator).

Awards and Honors:

William C. Menninger Award, Amer. College of Physicians, 1987.

The Distinguished Achievement Award, The New York Hospital-Cornell Med. Center, Ctr. Alumni Council, 1988.

Member, Institute of Medicine, National Academy of Sciences,1992.

The Johns Hopkins University Alumni Association Excellence in Teaching Award, 1992.

Joseph Zubin Award of the American Psychopathological Association, 1995.

Distinguished Service Award, The American College of Psychiatrists, 2002.

Visiting Scholar, The Phi Beta Kappa Society, 2003-2004.

Distinguished Life Fellow, American Psychiatric Association, 2003.

Paul Hoch Award of the American Psychopathological Association , 2006.

Rhoda and Bernard Sarnat International Award in Mental Health of the Institute of Medicine, 2008.

Distinguished Career Award. Society for the Study of Ingestive Behavior, 2009.

Doctor Honoris Causa. University of Zaragoza, Spain, 2012.

Representative Sample of Invited Lectures:

Distinguished Guest Lecturer at the Annual Meeting of The Royal College of Psychiatrists, London, England, July 5, 1978.

The Charles Getz, M.D. Memorial Lecture, The University of Maryland, School of Medicine, Baltimore, MD, March 6, 1979.

Dean's Lecture, The Johns Hopkins Medical Institutions Baltimore, MD, November 13, 1978.

Phineas J. Sparer Distinguished Visiting Professor, University of Tennessee, Memphis, TN, May 16, 1984.

Eastern Psychological Association Annual Meeting, New York, April 25, 1986.

Litchfield Lecturer, Univ. of Oxford, Oxford, England, June 1986.

Chairman, Symposium on Role of the Stomach in Regulation of Satiety. FASEB, Washington, D.C., March 31, 1987.

Telford Lecturer, Washington and Lee University, Lexington, Virginia, April 28, 1988.

Harvey Shein Memorial Lecturer. American Association of Directors of Psychiatric Residency Training, New Orleans, Louisiana, January 13, 1990.

Robert O. Jones Memorial Lecturer. Dalhousie University Medical School, Halifax, Nova Scotia, Canada, March 23, 1990.

Hasenbush Visiting Professor, Massachusetts Mental Health Center, Harvard Medical School, Boston, Mass., January 30, 1991.

Mapother Lecturer, Maudsley Hospital, Institute of Psychiatry, London, England, November 4, 1992.

William Paley Lecturer, Department of Medicine, Cornell Medical College, New York Hospital, February 4, 1993.

Theodore E. Woodward Lecturer, University of Maryland, April 15, 1993.

Sister Virgina Geiger Lecturer, College of Notre Dame of Maryland, Baltimore, Maryland, May 9, 1995.

Phi Beta Kappa Address, Washington & Lee University, Virginia, March 7, 1996.

Biele Lecturer, Thomas Jefferson University, Philadelphia, Pennsylvania, April 10, 1996.

Weniger Lecturer, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, April 26, 1996.

Taylor Lecturer in Neuropsychiatry, University of Maryland School of Medicine, Baltimore, Maryland, April 24, 1997.

Tumulty Lecturer, Johns Hopkins University School of Medicine, Baltimore, Maryland, May 14, 1997.

Mendelsohn Lecturer, New England Medical Center, Boston, Massachusetts, April 16, 1998.

Denny Brown Lecturer, Beth Israel Deaconess Hospital, Boston, Massachusetts, May 18, 2000.

Raymond D. Adams Honorary Lecture, Massachusetts General Hospital, Boston, Massachusetts, June 8, 2000.

Distinguished Psychiatrist Lecture, American Psychiatric Association, May 7, 2001.

PUBLICATIONS:

Books:

1. McHugh, P.R. and Slavney, P.R.: The Perspectives of Psychiatry, The Johns Hopkins University Press, Baltimore, MD, 1983.

   a. McHugh, P.R. and Slavney, P.R.: Perspectives de la Psiquiatria, Masson, Barcelona, Spain, 1985.

b. McHugh, P.R. and Slavney, P.R.: Psychiatriche Perspektiven, Springer-Verlag Berlin Heidelberg, Germany, 1984.

c. McHugh, P.R. and Slavney, P.R.: Les Perspectives de la Psychiatrie, Masson, Paris, France., 1986.

d. McHugh, P.R. and Slavney, P.R.: As Perspectivas da Psiquiatria, Artes Medicas, Porto Alegre, Brazil, 1988.

2. Slavney, P.R. and McHugh, P.R.: Psychiatric Polarities. The Johns Hopkins University Press, Baltimore, MD, 1987.

3. McHugh, P.R. and McKusick, V.A. (eds): Genes, Brain and Behavior. Assoc. Res. Nerv. Ment. Dis., Vol. 69, Raven Press, New York, 1990.

4. McHugh, P.R. and Slavney, P.R.: The Perspectives of Psychiatry, 2nd Edition, The Johns Hopkins University Press, Baltimore, MD, 1998.

5. McHugh, P.R.: The Mind Has Mountains: Reflections on Society and Psychiatry. The Johns Hopkins University Press, Baltimore, MD, 2006.

6. McHugh, P.R.: Try to Remember: Psychiatry's Clash Over Meaning, Memory, and Mind. Dana Press, 2008.

Papers:

1. Gibbons, J.L. and McHugh, P.R.: Plasma Cortisol in Depressive Illness. J. Psychiatr. Res., 1: 162, 1962.

2. Hays, R., McHugh, P.R., and Williams, H.: Absence of Thirst in Hydro-cephalus. New Engl. J. Med., 269: 277, 1963.

3. McHugh, P.R.: Occult Hydrocephalus. Quart. J. Med., 33: 297-308, 1964.

4. McHugh, P.R. and Smith, G.P.: Central Nervous System Control of Adreno-cortical Secretion. Symposium on Medical Aspects of Stress in the Military Climate. Walter Reed Army Institute of Research, 421-429, April 1964.

5. Smith, G.P., Boren, J. and McHugh, P.R.: Gastric Secretory Response to Acute Environmental Stress. Symposium on Medical Aspects of Stress in the Military Climate. Walter Reed Army Institute of Research, 353-365, April 1964.

6. McHugh, P.R., Black, W.C. and Mason, J.M.: Some Hormonal Responses to

Electrical Self Stimulation in the Macaca Mulatta. Am. J. Physiol., 210: 109-113, 1966.

7. McHugh, P.R.: Hydrocephalic Dementia. Bull. N.Y. Acad. Med., 42:907-917, 1966.

8. McHugh, P.R. and Smith, G.P.: The Plasma 17-OH-CS Response to Amygdaloid Stimulations With and Without After-Discharges. Am. J. Physiol., 212: 619-622, 1967.

9. McHugh, P.R. and Smith, G.P.: Negative Feedback in Adrenocortical response to limbic stimulation in Macaca Mulatta. Am. J. Physiol., 213: 1445-1450, 1967.

10. Smith, G.P. and McHugh, P.R.: Gastric Secretory Response to Amygdaloid or Hypothalamic Stimulation in Monkeys. Am. J. Physiol., 213: 640-644, 1967.

11. Reis, D.J. and McHugh, P.R.: Hypoxia as a Cause of Bradycardia During Amygdala Stimulation in Monkey. Am. J. Physiol., 214: 601-610, 1968.

12. McHugh, P.R.: Hypothalamic Controls in Feeding Behavior as Revealed by "Disconnection" Method. In: Transactions of the American Neurological Association, 95: 100-103, 1970.

13. McHugh, P.R. and Goodell, H.: Behavior of Patients with Sedative Poisoning Seen in a General Hospital. Archives of General Psychiatry, 25: 256-264, 1971.

14. Andersen, A. and McHugh, P.R.: Oat Carcinoma with Hyperadrenalism Manifesting Itself as a Suicide Attempt. Journal of Nervous and Mental Disease, 152: 6, 1971.

15. McHugh, P.R. and Gibbs, J.: Aspects of Subcortical Organization of Feeding Revealed by Hypothalamic Disconnections in Macaca Mulatta. Brain, 95: 279-293, 1972.

16. Folstein, M., Folstein, S., and McHugh, P.R.: Clinical Predictors of Improvement After Electroconvulsive Therapy of Patients with Schizophrenia, Neurotic Reactions, and Affective Disorders. Biological Psychiatry, 7: 147-152, 1973.

17. Slavney, P.R. and McHugh, P.R.: The Hysterical Personality: A Controlled Study. Archives of General Psychiatry, 30: 325-329, 1974.

18. Luria, R. and McHugh, P.R.: The Reliability and Clinical Utility of the Present

State Examination. Archives of General Psychiatry, 30: 866-871, 1974.

19. Sovner, R. and McHugh, P.R.: Lithium Treatment in Periodic Catatonia. The Journal of Nervous and Mental Disease, 158: 214-221, 1974.

20. Breakey, W.R., Goodell, H., Lorenz, P.L. and McHugh, P.R.: Hallucinogenic Drugs as Precipitants of Schizophrenia. Psychol. Med., 4: 255-261, 1974.

21. Robinson, R.G., McHugh, P.R. and Folstein, M.F.: Measurement of Appetite Disturbances in Psychiatric Disorders. J. Psychiat. Res., 12: 59-68, 1975.

22. Slavney, P.R. and McHugh, P.R.: The Hysterical Personality: An Attempt at Validation with the MMPI. Archives of General Psychiatry, 32: 186-190, 1975.

23. McHugh, P.R. and Folstein, M.F.: Psychiatric Syndromes of Huntington's Chorea: A Clinical and Phenomenological Study. Seminars in Psychiatry. In Psychiatric Aspects of Neurologic Disease. D. Frank Benson, M.D. and Dietrich Blumer, M.D., Ed. Grune & Stratton, New York, pp. 267-286, 1975.

24. Von Greif, H., McHugh, P.R., and Stokes, P.: The Familial History in Sixteen Males with Bipolar Manic-Depressive Illness. In Genetic Research in Psychiatry. R.R. Fieve, D. Rosenthal, and H. Brill, Ed. The Johns Hopkins University Press, 233-239, 1975.

25. Folstein, M., Folstein, S., and McHugh, P.R.: "Mini-Mental State": A Practical Method for Grading the Cognitive State of Patients for the Clinician. Journal of Psychiatric Research, 12: 189-198, 1975. **[CITATION CLASSIC, 1989]**.

26. Robinson, R.G., McHugh, P.R. and Bloom, F.E.: Chlorpromazine Induced Hyperphagia in the Rat. Psychopharmacology Communications, 1: 37-50, 1975.

27. Sovner, R. and McHugh, P.R.: Bipolar Course in Schizoaffective Illness. Biological Psychiatry, 11: 195-204, 1976.

28. McHugh, P.R., Gibbs, J., Falasco, J.D., Moran, T. and Smith, G.P.: Inhibitions of Feeding Examined in Rhesus Monkeys with Hypothalamic Disconnections. Brain, 98: 441-454, 1975.

29. Gibbs, J., Falasco, J. and McHugh, P.R.: Cholecystokinin Decreases Feeding in Rhesus Monkeys. Am. J. Physiol., 230: 15-18, 1976.

30. McHugh, P.R., Moran, T.H. and Barton, C.N.: Satiety: A Graded Behavioral Phenomenon Regulating Caloric Intake. Science, 190: 167-169, 1975.

31. McHugh, P.R. and Moran, T.H.: An Examination of the Concept of Satiety in Hypothalamic Hyperphagia. In: Anorexia Nervosa, R. Vigersky, Ed. Raven Press, New York, 1977, pp. 67-73.

32. Slavney, P.R., Rich, G.B., Pearlson, G.D. and McHugh, P.R.: Phencyclidine Abuse and Symptomatic Mania. Biol. Psychiat., 12: 697-700, 1977.

33. McHugh, P.R., Moran, T.H.: The Accuracy of the Regulation of Caloric Ingestion in the Rhesus Monkey: Caloric Regulation in Rhesus Monkeys. Am. J. Physiol., 235: R29-34, 1978.

34. Folstein, M.F., Maiberger, R. and McHugh, P.R.: Mood Disorder as a Specific Complication of Stroke. Journal of Neurology, Neurosurgery and Psychiatry, 40, 1018-1020, 1977.

35. Folstein, M.F. and McHugh, P.R.: Defective Long Term Caloric Regulation in Obesity. NIDA Research Monograph Studies, 20: 182-188, 1978.

36. McHugh, P.R. and Folstein, M.F.: Psychopathology of Dementia: Implications for Neuropathology: Res. Publ. Assoc. Res. Nerv. Ment. Dis. 57: 17-30, 1978

37 Folstein, M.F. and McHugh, P.R. Dementia Syndrome of Depression in Alzheimer's disease. In Senile Dementia and Related Disorders. Katzman, R. et al., Eds., New York: Raven Press, pp. 87-96, 1978.

38. Robinson, R.G., Folstein, M.F. and McHugh, P.R. Reduced Caloric Intake Following Small Bowel Bypass Surgery: A Systematic Study of Possible Causes. Psychol. Med., 9: 37-53, 1979.

39. McHugh, P.R.: Aspects of the Control of Feeding: Application of Quantification in Psychobiology. The Johns Hopkins Medical Journal, 144: 147-155, 1979.

40. McHugh, P.R., Moran, T.H.: Calories and Gastric Emptying: A Regulatory Capacity with Implications for Feeding. American Journal of Physiology, 236: R254-R260, 1979.

41. Folstein, S.E., Folstein, M.F., McHugh, P.R.: Psychiatric Syndromes in Huntington's Disease. Advances in Neurology, 23: 281-289, Raven Press, New York, 1979.

42. Robinson, R.G., Folstein, M.F., Simonson, M., McHugh, P.R.: Differential Antianxiety Response to Caloric Intake Between Normal and Obese

Subjects. Psychosomatic Medicine, 42: 415-427, 1980.

43. Moran, T.H., McHugh, P.R.: Distinctions Amongst Three Sugars in Their Effects on Gastric Emptying and Satiety. American Journal of Physiology, 241: R25-R30, 1981.

44. Rabins, P.V., Tune, L.E., McHugh, P.R.: Tardive Dyskinesia. The Johns Hopkins Medical Journal, 148: 206-211, 1981.

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46. Pearlson, G.D., Veroff, A.E., McHugh, P.R.: The Use of Computed Tomography in Psychiatry: Recent Applications to Schizophrenia, Manic-depressive Illness and Dementia Syndrome. The Johns Hopkins Medical Journal, 149: 194-202, 1981.

47. Tune, L.E., McHugh, P.R., Coyle, J.T.: Drug Management in Chronic Schizophrenia. The Johns Hopkins Medical Journal, 150: 45-48, 1982.

48. Moran, T.H., McHugh, P.R.: Cholecystokinin Suppresses Food Intake by Inhibiting Gastric Emptying. American Journal of Physiology, 242: R491-R497, 1982.

49. McHugh, P.R., Slavney, P.R.: Methods of Reasoning in Psychopathology: Conflict and Resolution. Comprehensive Psychiatry, 23: 197-215, 1982.

50. Tune, L.E., Folstein, M., Rabins, P., Jayaram, G., McHugh, P.R.: Familial Parkinson's Disease: A Case Report. The Johns Hopkins Medical Journal, 151: 65-70, 1982.

51. McHugh, P.R., Moran, T.H., Wirth, J.B.: Post-Pyloric Regulation of Gastric Emptying in Rhesus Monkeys. American Journal of Physiology, 243: R403-R415, 1982.

52. Hunt, J.N., McHugh, P.R.: Does Calcium Mediate the Slowing of Gastric Emptying in Primates? American Journal of Physiology, 243: G200-G203, 1982.

53. Brener, W., Hendrix, T.R., McHugh, P.R.: Regulation of the Gastric Emptying of Glucose. Gastroenterology, 85: 76-82, 1983.

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55. McHugh, P.R., Robinson, R.G.: The Two Way Trade—Psychiatry and Neuroscience. The British Journal of Psychiatry, 143: 303-305, 1983.

56. McHugh, P.R.: The Control of Gastric Emptying. Journal of Autonomic Nervous System, 9: 221-231, 1983.

57. Slavney, P.R., McHugh, P.R.: Life Stories and Meaningful Connections Reflections on a Clinical Method in Psychiatry and Medicine. Perspectives in Biology and Medicine, 27: 279-288, 1984.

58. Smith, G.T., Moran, T.H., Coyle, J.T., Kuhar, M.J., O'Donahue, T.L. and McHugh, P.R.: Anatomic Localization of Cholecystokinin Receptors to the Pyloric Sphincter. American Journal of Physiology, 246: R127-R130, 1984.

59. McHugh, P.R., Moran, T.H.: The Stomach: A Conception of its Dynamic Role in Satiety. Progress in Psychobiology and Physiological Psychology, 11: 197-232, Ed. A. Epstein and J. Sprague, Academic Press, Inc., 1985.

60. McHugh, P.R. Commentary on Charles Hanly's "Logical and Conceptual Problems of Existential Psychiatry". The Journal of Nervous and Mental Disease, 173: 278, 1985.

61. Slavney, P.R., McHugh, P.R.: The Life-Story Method in Psychotherapy and Psychiatric Education: The Development of Confidence. American Journal of Psychotherapy, 39: 57-67, 1985.

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63. Robinson, P.H., Moran, T.H., McHugh, P.R.: Gastric Cholecystokinin Receptors and the Effect of Cholecystokinin on Feeding and Gastric Emptying in the Neonatal Rat. Annals of the New York Academy of Science, 448: 627-629, 1985.

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65. Nestadt, G., McHugh, P.R.: The Frequency and Specificity of Some "Negative" Symptoms. Weissnauer Symposium, Basisstadien endogener Psychosen und das Borderline-Problem. Ed. G. Huber, Schattauer, Stuttgart-New York, 1985.

66. Folstein, M., Romanoski, A., Nestadt, G., Chahal, R., Merchant, A., Shapiro, S., Kramer, M., Anthony, J., Gruenberg, E., McHugh, P.R.: Brief Report on the

Clinical Reappraisal of the Diagnostic Interview Schedule Carried Out at the Johns Hopkins Site of the Epidemiological Catchment Area Program of the NIMH. Psychological Medicine, 15: 809-814, 1985.

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69. McHugh, P.R., Moran, T.H. The Stomach and Satiety. In: Interaction of the Chemical Senses with Nutrition. Ed. M.B. Kare, Academic Press, 167-180, 1986.

70. Notturno, M.A., McHugh, P.R.: Is Freudian Psychoanalytic Theory Really Falsifiable? Behavioral and Brain Sciences, 9: 250-252, 1986.

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72. McHugh, P.R., Moran, T.H.: The Inhibition of Feeding Produced by Direct Intraintestinal Infusion of Glucose: Is This Satiety? Brain Research Bulletin, 17: 415-418, 1986.

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75. Robinson, P.H., Moran, T.H., Goldrich, M., McHugh, P.R. Development of Cholecystokinin Binding Sites in Rat Upper Gastrointestinal Tract. Am. J. Physiol., 252: G529-G534, 1987.

76. McHugh, P.R. Psychiatry and Its Scientific Relatives: "A Little More Than Kin and Less Than Kind." Journal of Nervous and Mental Disease, 175: 579-583, 1987.

77. Notturno, M.A., McHugh, P.R. Is Freudian Psychoanalytic Theory Really Falsifiable? Metaphilosophy, 18: 306-320, 1987.

78. McHugh, P.R. William Osler and the New Psychiatry. Annals of Internal Medicine, 107: 914-918, 1987.

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EXHIBIT D

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

COMMENTARY

Witches, multiple personalities, and other psychiatric artifacts

Contemporary psychiatric misdirections derived primarily from standard medical errors of oversimplification, misplaced emphasis, and invention are reviewed. These particular errors, however, were in part prompted and sustained by the sociocultural fads and fashions of the day. The results have been disastrous for everyone — patients, families, the public and psychiatry itself.

PAUL R. McHUGH

Psychiatry is a medical discipline long on disorders and short on explanations. Just a glance at the *Diagnostic and Statistical Manual* now in its fourth edition (DSM-IV) will confirm this verdict. DSM-IV presents hundreds of psychiatric disorders arranged according to their symptoms—depression, anxiety, schizophrenia and the like—but quite scrupulously avoids an etiological arrangement. Its authors are aware that psychiatrists tend to split up into camps, based on purported explanation — hence, biological, dynamic, behavioural, and even the eclectic — and go to war with one another.

However, this shortage of agreed-upon explanations brings good news and bad news. The good news is there is plenty of room for useful scientific research in psychiatry and a great deal of this is going on at the moment[1]. The bad news is, because practitioners in this discipline are hungry for explanations today, at least once each decade, psychiatry is swept by an enthusiasm for a fundamentally incoherent practice, and then must spend at least ten years subsequently digging out of the troubles that this practice produced. These misdirections of psychiatry rest squarely on standard medical mistakes such as oversimplification, misplaced emphasis or pure invention. The enthusiasms for these misdirections, however, usually derive from an uncritical acceptance of transient cultural attitudes and fashionable ideas. The repeated combination of these elements proves how all too often the discipline of psychiatry has been the captive of culture, to the detriment of everyone.

Anti-psychiatry

The most conspicuous misdirection of psychiatric practice — the precipitate dismissal of patients with severe, chronic mental disorders such as schizophrenia, from psychiatric hospitals — required a vastly oversimplified view of mental illness. Ironically, these actions were defended as efforts to bring 'freedom' to these people, sounding a typical 1960s cultural theme that marched right by the fact that it was the patients' illnesses that had deprived them of freedom in the first place. There were several collaborators in this sad enterprise. Prominent among them were state governments looking for release from the traditional but heavy fiscal burden of housing the mentally ill. Crucial to the process was the combination of fashionable opinions of the era about society's institutions as oppressive and oversimplified explanatory opinions about schizophrenia and other mental illnesses generated by the so-called anti-psychiatrists, Thomas Szasz, R.D. Laing, Erving Goffman, and Michel Foucault, notably among them.

A simple description of the mental problems of psychiatric patients was not the style of our 1960s commentators. They were more interested in painting a picture of their own devising. A picture that would provoke first suspicion and then disdain for contemporary psychiatric practices. And it did so, not by producing new standards or reforming specific practices, but by ridiculing and caricaturing efforts of the doctors and the institutions, just as fashion directed. The power of scorn was surprising and had amazing results, leading many in the public and not a few in the profession to believe that it was the institutions that provoked the patients' troubles rather than illness that called out for shelter and treatment. Here from Szasz's book, *Schizophrenia — The Sacred Symbol of Psychiatry*[2], is a typical comment: "The sense in which I mean that Psychiatry creates schizophrenia is readily illustrated by the analogy between institutional psychiatry and involuntary servitude. If there is no slavery there can be no slaves . . . . Similarly if there is no psychiatry there can be no schizophrenics. In other words, the identity of an individual as a schizophrenic depends on the existence of the social system of (institutional) psychiatry."

Effective replies to such commentary demanded knowledge first of the patients themselves, in schizophrenia, people impaired by delusions, hallucinations and disruptions of thinking capacities, but also understanding of how the concept of disease has, essentially since Sydenham, provided physicians with a coherent, logical, and stepwise approach to human afflictions, from symptom clusters to etiology, ultimately. The disparagement of this approach by the likes of Szasz demonstrated an ignorance of the explanatory potential of the concept of disease right from the start.

A saving grace for any medical theory or practice (the thing that spares it perpetual thralldom to the gusty winds of fashion) is the patients. They are real, they are around and a knowledge of their distressing symptoms guards against oversimplification. The claim that schizophrenic patients are in any sense living an alternative life style that our institutions were inhibiting was fatuous. Every urban citizen now recognizes, because of a familiarity with the many homeless people that the anti-psychiatric fad generated, that these patients have impaired capacities to comprehend the world and that they need protection and serious active treatment.

As well, and fortunately, the enterprises of brain research launched subsequent to these pronouncements have documented a cerebral source for many of the particular symptoms of schizophrenia[3,4]. This research tends to confirm that the conceptual model of epilepsy that helped sort out that condition (distinguishing symptomatic epilepsies, caused by some coarse brain pathology, from the idiopathic epilepsies, that rest upon genes) also makes sense of the group of conditions called schizophrenia[5]. The ultimate solutions for the homeless mentally ill are still to

be found but, as the saying goes, the anti-psychiatrists are history.

A question of gender

A similar combination of a cultural fad amidst a dearth of explanations led to the grim practice of sex reassignment surgery in the 1970s. I happen to know about this because Johns Hopkins was one of the places in the United States where this practice, with what at the time were called transsexuals, was given its start.

Typically a man comes to the clinic and says something like, "As long as I can remember, I've thought I was in the wrong body. True, I've married and had a couple of kids but always, in the back and now more often in the front of my mind, there's this idea that actually I'm more a woman than a man. I'm here because all this male equipment is disgusting to me. I want medical help to change my body: hormone treatments, silicone implants, surgical amputation of my genitalia and the construction of a vagina. Will you do it?"

. . . psychiatrists do not understand what is the problem here but hope surgery may do the poor wretch some good.

The patient claims it is a torture for him to live as a man, especially now that he has read in the newspapers about the possibility of switching surgically to womanhood. Upon examination it is not difficult to identify other mental and personality difficulties in him, but he is primarily disquieted because of his intrusive thoughts that his sex is not a settled issue in his life.

The skills of our plastic surgeons, particularly on the genitourinary system, are impressive. They were obtained, however, not to treat a presumptive gender identity problem but to repair congenital defects, injuries and the effects of destructive diseases such as cancer in this region of the body. That you can get something done doesn't always mean that you should do it. There are so many problems right at the start. In sex reassignment cases, the patient's claim that this has been a lifelong problem is seldom checked with others who have known him since childhood. It seems so intrusive and untrusting to discuss the problem with others even though they might provide a better gauge of the seriousness of the problem, how it emerged, its fluctuations of intensity over time and its connection with other experiences. When you discuss what the patient means by "feeling like a woman," you often get a sex stereotype in return and something that female physicians note immediately as a male caricature of women's attitudes and interests. One of our patients, for example, said that, as a woman, he would be more "invested with being than with doing."

Experts say that a sense of one's own maleness or femaleness rests upon a complicated biopsychological process and suggest that some derangement in this natural process may be the explanation for this problem. They venture that, although their research on those born with genital and hormonal abnormalities may not apply to a person with normal bodily structures, something must have gone wrong in this patient's early and formative life to cause him to feel as he does. Why not help him look more like what he says he feels? Our surgeons can do it.

On the other hand it is not obvious how this patient's sense that he is a woman trapped in a man's body differs from the feelings of a patient with anorexia nervosa that she is obese despite her emaciated, cachectic state. We don't do liposuction on anorexics. So why amputate the genitals of these patients? Surely, the fault is in the mind, not the member.

A plastic surgeon at Hopkins provided the voice of reality on this matter based on his practice and his natural awe at the mystery of the body. One day while we were talking about it, he said to me: "Imagine what it's like to get up at dawn and think about spending the day slashing with a knife at perfectly well formed organs, because you psychiatrists do not understand what is the problem here but hope surgery may do the poor wretch some good."

The zeal for this sex change surgery did not derive from critical reasoning or thoughtful assessments. The energy came from the fashions of the 1970s that invaded the clinic. If you can do it and he wants it, do it. This fashion was intregal to an aesthetic that saw diversity as everything, and could accept any idea, including that of surgical sex change, as interesting, and resistance to such ideas as uptight or even oppressive. Yet, moral matters should have some salience here. These include the confusions imposed on society where these men/women insist on acceptance even in athletic competition with women; the encouragement of the 'illusion of technique' which assumes that the body is like a suit of clothes to be hemmed and stitched to style; there is the ghastliness of the mutilated anatomy to consider; and finally, consider that this surgical practice has distracted effort from genuine investigations attempting to find out just what has gone wrong for these people. What has, by their testimony, given them years of torment and psychological distress and prompted them to accept these grim and disfiguring surgical procedures.

We now appreciate that this condition falls into the category of "overvalued ideas"[6] described very thoroughly by Carl Wernicke[7] at the beginning of the century. This is a category that includes morbid jealousies, anorexia nervosa and litigious personalities. Fortunately the diagnostic term transsexualism has been abandoned and replaced with the term Gender Identity Disorder making it clear that the problem is one of ideas rather than of bodily constitution and should be treated as such.

Psychiatrists collaborated in an exercise of folly with distressed people. and a misplaced emphasis proved hazardous when explanations were at a premium.

Artifactual behaviour

Medical errors of oversimplification and misplaced emphasis usually play themselves out with consequences all can see. Pure inventions can bring out a darker, hateful potential when psychiatric thought goes awry in search for an explanation. Most psychiatric histories choose to describe such invention by detailing its most vivid example — witches. The experience in Salem, Massachusetts, of 300 years ago is prototypical[8].

Briefly, in 1692, several young women and girls who had for some weeks been secretly listening to tales of spells, voodoo, and illicit cultic practices from a Barbados slave suddenly displayed a set of mystifying mental and behavioural changes. They developed trance-like states, falling on the ground and flailing, and screaming at night and at prayer, seemingly in great distress and in need of help. The local physician, who witnessed this, was as bewildered as anyone else and eventually made a diagnosis of "bewitchment". "The

evil hand is on them", he said and turned them over to the local law officials for examination and ultimately for protection. The clergy and magistrates assumed, taking their lead from the doctor, that local agents of Satan were at work and, using as grounds the answers of these young women to leading questions, indicted several citizens for bewitching them. The accepted proof of guilt was bizarre. The young women spoke of ghostly visitations by the defendants to their homes to torment them, all occurring while the accused were known by the testimony of reliable witnesses to be elsewhere. The victims often screeched out in court that they felt the accused pinching them even as everyone could see the defendants sitting quietly on the other side of the court room. Strange as it seems this testimony had great weight because the judges and the juries believed that capacities of this kind — provoking injury from a distance or being in two places at the same time — were skills and powers of witches. On the basis of this "spectral" evidence they dismissed all protests of innocence by the defendants and promptly executed them. The whole exercise should have been discredited when, after the executions, there was no change in the distraught behaviour of the young women. Instead more and more citizens were indicted. Eventually, good sense began to prevail, in part because many citizens came to recognize that no one was safe against these accusations and in part because a prosecution depending on spectral evidence was recognized to be as irrefutable as it was undemonstrable. The trials ceased and ultimately several of the young women admitted that their beliefs had been "delusions" and their accusations false.

A psychiatric or psychological artifact . . . is a product of human crafting.

The proper psychiatric diagnosis for those young women is, of course, not bewitchment but any of a series of terms such as hysteria, factitious disorder or malingering, all attempting to communicate the view that the mental states and behaviours of these individuals should be recognized as artifacts. A psychiatric or psychological artifact, like a physical artifact, is a product of human crafting. It is not a product of nature, such as a disease, but something manufactured by some person or persons for some human purpose or action. Behavioural displays in which physical or mental disorders are imitated (artifactual clinical disorders) are common enough on any medical service. On inspection, the patient's manufactured imitations of illness derive from a variety of different sources of information and suggestion, and they serve a variety of personal goals. In this era artifactual clinical conditions usually represent an effort on the part of a troubled person to take on the sick role with the benefits of care, attention and support this status brings to an individual. The status of 'bewitched' in Salem of 1692 brought both attentive concern and the license to indict any enemy to young women previously scarcely noticed by the community.

Forms of artifactual behaviour whether they are physical activities, such as falling and shaking, or mental phenomena, such as pains, visions or memories are partially shaped by unintended suggestions from others and sustained by the attention of onlookers and especially onlookers such as doctors who are socially empowered to assign, by affixing a diagnosis, the status of patient to a person. Whenever a diagnostician mistakes an artifact for what it is attempting to imitate by misidentifying the artifact either as some natural process, such as epilepsy, or inventing some specious explanation for it, such as bewitchment, then the behavioural display will continue, expand, prove treatment resistant and, in certain settings, spread to others. The usual result is trouble. Over the last decade a remarkable example of manufactured artifactual behaviour has surfaced and has been misidentified and bolstered by an invented view of its cause that fits a cultural fashion. This condition is Multiple Personality Disorder (MPD).

Today's awful version of psychiatric invention is the notion that many people suffered sexual abuse — if only they remembered.

Multiple personality disorder

Patients who are eventually diagnosed as suffering from MPD come to therapists with standard psychiatric complaints such as depression or anxiety. Some therapists see much more in these symptoms and suggest to the patient, and to others, that the symptoms represent the subtle actions of several alternative personalities, alters, coexisting in the patient's mental life. These suggestions encourage many patients to see their problems in a new light. Suddenly they are transformed into odd people with repeated shifts of demeanor and deportment that they display on command and sometimes in response to hand signals from the therapist. An artifactual behaviour has been generated by the combination of the vulnerabilities of the patient to suggestion and the beliefs of the therapists.

Sexual politics in the 1980s and 1990s, particularly about sexual oppression and victimization, galvanizes these inventions. Forgotten (repressed) sexual mistreatment is the proffered explanation of MPD. Just as an epidemic of bewitchment served to prove the arrival of Satan in Salem, so in our day an epidemic of MPD is used to propose that a vast number of adults were sexually abused by guardians during their childhood, the MPD being one of the presumed expressions of the traumatic experience. Now, I do not for a moment deny that children are sometimes victims of sexual abuse or that such abuse would produce psychiatric symptoms. Such realities are not at issue. What I am concerned with here is what has been imagined from these realities and inventively applied.

Adults with MPD, so theory goes, were assaulted as young children by a trusted and beloved person, usually a father although grandfathers, uncles, brothers, or others, often abetted by women in their power, are also possibilities. This sexual assault, the theory holds, is blocked from memory (repressed and dissociated) because it was so shocking. This dissociating blockade itself is purported to destroy the integration of mind and evokes multiple personalities as separate, disconnected, sequestered, 'alternative' collections of thought, memory and feeling. These resultant distinct 'personalities' produce a variety of what might seem standard psychiatric symptoms, such as depression, weight problems, panic states or demoralization, that only careful review, by experts on psychic life, will reveal to be expressions of MPD and the outcome of sexual abuse.

These patients have not come to treatment reporting a sexual assault in childhood. Only as the therapy is developed is the possibility that they were sexually abused as children suggested to them. From recollections of the mists of childhood, a vague sense of vulnerability may

slowly emerge, facilitated and encouraged by the treating group. This sense of vulnerability is thought a harbinger of clearer memories of victimization that, although buried, have been active for decades producing the different 'personalities'. The long 'forgotten' abuse is finally 'remembered' after sessions of 'uncovering' therapy, during which long conversations take place, often enhanced by sodium amytal or by hypnotic inductions, between the therapist and alter personalities, personalities that usually will be of all age ranges, differing sexes and not uncommonly animals that must also be made to speak.

Any actual proof of the provocative sexual assault is thought unnecessary since the presence of the MPD is thought proof enough. Theory about how the mind works and how its manifestations are to be understood is considered quite adequate to accuse the patient's parents of vile and atrocious acts against the patient when she (some 85% are women) was a child, with nothing more than this new form of spectral evidence, evidence that is just as irrefutable as that at Salem.

The idea of MPD and its cause has caught on among large numbers of psychotherapists. Its partisans see the patients as victims, cosset them in groups, encourage more expressions of alters (up to as many as 100 or more), and are ferocious towards any defenders of the perpetrators of the abuse. Just as the divines of Massachusetts were convinced that they were fighting Satan by recognizing bewitchment, so the contemporary divines, these therapists, are confident that they are fighting sexual oppression and child abuse, by recognizing MPD. The incidence of MPD has of late taken on epidemic proportions particularly in certain treatment centers. Whereas its diagnosis was reported less than 200 times from a variety of supposed causes prior to 1970, it has been applied to more than 20,000 people in the last decade and largely attributed to sexual abuse.

I have been involved, either directly or indirectly, with more than thirty such cases in the last few years. In every one, the very same story has been played out in a stereotyped script-like way. In each, a young woman with a rather straightforward set of psychiatric symptoms (depression and demoralization) sought psychotherapeutic help and her case was stretched during a course of therapy into a diagnosis of repressed memories of sexual abuse, a delayed form of Post Traumatic Stress Disorder and usually MPD. In each case, an accusation of prior sexual abuse was levelled by her, usually against her father but in about thirty percent of cases against the mother. The accusation developed, always after the onset of therapy, first as vague feelings of dream-like childhood reminiscences of danger and darkness and eventually crystallizing, sometimes in a flash, into a recollection of father forcing sex upon the patient as a child. No other evidence of these events was presented. Refuting testimony, coming from former nursemaids or the other parent for example, was dismissed if presented.

On one occasion, the identity of the molester changed. This change was as telling about the nature of evidence as was the emergence of the original charge. A woman called her mother to

IMAGE
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The Salem witch trial

Bettmann Archives

claim that she had come to realize that when she was young she was severely and repeatedly sexually molested by a maternal uncle. The mother questioned the daughter about the dates and times of these incidents to determine if they were even possible. She soon discovered that her brother was on military service in Korea at the time of the alleged abuse and with this information, the mother went to her daughter with the hope of showing her that her therapist was misleading her in destructive ways. When she heard this new information, the daughter seemed momentarily taken aback, but then said, "I see, Mother. Yes. Well, let me think. If your dates are right, I suppose it must have been Dad." And with that, she began to claim that she had been a victim of her father's abusive attentions and nothing could dissuade her.

The accused parents whom I studied, denying the charges and amazed at their source, submitted to detailed reviews of their sexual lives and any other efforts up to and including polygraphic testing to try to prove their innocence. Professional requests by me to the daughters' therapists for better evidence of the abuse were dismissed as derived from the pleadings of the guilty and were deemed beneath contempt given that the diagnosis of MPD indicated, and the ultimate testimony of the patient's patently confirmed, the sex abuse.

Remembered trauma

In Salem, the convictions of the defendants depended on how judges thought witches behaved. In our day, similar convictions depend on how some therapists think memory of trauma customarily works. In fact, standard psychiatric teaching in the past held that severe traumas are usually remembered all too well. They are amplified in consciousness, remaining like grief to be reborn and re-emphasized on anniversaries and in settings that can simulate the environments where they occurred. Good evidence for this was found in the memories of children from concentration camps. More recently, the children of Chowchilla, California, who were kidnapped in their school bus and buried in sand for many hours, remembered every detail of their traumatic experience years later and needed psychiatric assistance, not to bring out forgotten material that was repressed but to help them move away from a constant ruminative preoccupation with the experience[9].

Many psychiatrists upon first hearing of these diagnostic formulations (MPD being a form of post traumatic stress and the result of repressed memories of sexual abuse in childhood) have fallen back upon what they think is an even-handed way of approaching it. The mind is very mysterious in its ways, they say, anything is possible in a family. In fact, this credulous stance towards evidence and the failure to consider the alternative of artifactual behaviours, memories and beliefs continue to support this crude psychiatric analysis, and if the kinds of practices that lie behind the diagnosis of MPD become standard in psychiatry, then no family with a member in psychotherapy is safe from a persecution galvanized by the same kind of energy and reasoning that launched the witches' court or the lynch mob.

The helpful clinical approach to the patient with putative MPD, as with any instance of an artifactual display, is to direct attention away from the manufactured behaviour — one simply never talks to an alter. Within a few days of a consistent therapeutic focus away from the MPD behaviour and on to the issues of depression and anxiety that were the presenting matters, preoccupations with alters and supposed repressed memories fade and generally useful psychotherapy begins.

This epidemic will end in the same way that the witch craze ended in Salem. The MPD phenomena will be seen as manufactured, the 'repressed memory' explanations will be recognized as misguided, and psychiatrists will become immunized against the practices that generated these artifacts[10]. Meanwhile, time is passing, many families are being hurt and confidence in the competence and impartiality of psychiatry is eroding.

A time to learn

Major psychiatric misdirections often share this intimidating mixture of a medical mistake and a trendy idea. Any challenge to such a misdirection must confront simultaneously the professional authority of the proponents and the political power of fashionable convictions. Such challenges are not for the faint-hearted or inexperienced. They seldom quickly succeed because they are often misrepresented as ignorant or, in the cant word of our day, uncaring.

In ten years much damage can be done, and much effort over a longer period of time is required to repair it. Thus with the mentally ill homeless, only a new crusade and social commitment will bring them adequate psychiatric services again. Age increases the sad caricature of the sexual reassigned and saps their bravado. Some, pathetically, even ask about re-reassignment. And groups of parents falsely accused of sexual mistreatment by their grown children are gathering together to fight back against psychotherapists in ways that are producing dramatic but distressing court room spectacles. How good it would have been if all these misguided programs had been avoided or at least their span abbreviated.

Psychiatry is a medical discipline. It is capable of medical triumphs and serious medical mistakes. We don't know the secret of human nature. We cannot build the New Jerusalem. We can describe how our explanations for mental disorders are devised and develop, and where they are strong and where they are limited. We can clarify the presumptions about what we know and how we know it. With more research, steadily, we can construct a clinical discipline that, while delivering less to fashion, will bring more to patients and their families.

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EXHIBIT E

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

HA40.Y **Other specified aetiological considerations in sexual dysfunctions and sexual pain disorders**

Gender incongruence (BlockL1-HA6)

Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.

Exclusions: Paraphilic disorders (BlockL1-6D3)

HA60 **Gender incongruence of adolescence or adulthood**

Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions: Paraphilic disorders (BlockL1-6D3)

HA61 **Gender incongruence of childhood**

Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions: Paraphilic disorders (BlockL1-6D3)

HA6Z **Gender incongruence, unspecified**

HA8Y **Other specified conditions related to sexual health**

HA8Z **Conditions related to sexual health, unspecified**

EXHIBIT F

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

AMERICAN PSYCHOLOGICAL ASSOCIATION

Exhibit 0012 McHugh

APA RESOLUTION on Gender Identity Change Efforts

FEBRUARY 2021

The foundational professional guideline for working with gender diverse persons acknowledges that, "Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth." (APA, 2015, p. 834). Gender identity refers to "a person's deep felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; [or another] gender" (APA, 2015, p. 862). While gender refers to the trait characteristics and behaviors culturally associated with one's sex assigned at birth, in some cases, gender may be distinct from the physical markers of biological sex (e.g., genitals, chromosomes). Gender identity is also distinct from gender expression, which refers to "the presentation of an individual including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity" (APA, 2015, p. 861). Cisgender refers to "a person whose gender identity aligns with sex assigned at birth" (e.g., an individual assigned female at birth who identifies as a woman/girl; APA, 2015, p. 861). Transgender is "an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth" (APA, 2015, p. 863). For the purpose of this resolution, we are using a broad definition of transgender to include transgender women/girls, transgender men/boys, nonbinary individuals (i.e., people who may identify as a gender other than a woman/girl or a man/boy), and any individual who articulates a gender identity different from societal expectations based on their sex assigned at birth.

Some transgender and gender nonbinary individuals seek gender-affirming medical care (e.g., hormone therapy, surgery) while others do not. Similarly, some transgender and gender nonbinary individuals seek to change their gender marker and/or their name on legal documents, while others do not. In this resolution, we strive to be inclusive of all gender diversity regardless of a person's pursuance of social, medical, or legal transition.

The fields of psychiatry and psychology have a long history of pathologizing individuals and those who question their gender identity (Barkai, 2017; Benson, 2013; Bouman et al, 2014; Burke, 2011; Drescher, 2010; Nadal et al., 2010; Riggs et al. 2019). This history is informed by, and parallels, the larger Western and United States-based, medical-model, narratives that 1) define gender as binary and conflate it with physical markers, 2) define masculinity, and characteristics historically attributed to men/boys, as superior to femininity and characteristics historically attributed to women/girls, 3) create systems that confer privilege to cisgender people and label cisgender identities and expressions as normative, 4) discriminate against transgender and gender nonbinary individuals (Stryker, 2017).

Gender identity change efforts (GICE) refer to a range of techniques used by mental health professionals and non-professionals with the goal of changing gender identity, gender expression, or associated components of these to be in alignment with gender role behaviors that are stereotypically associated with sex assigned at birth, (Hill et al., 2010; SAMHSA, 2015). In addition to explicit attempts to change individuals' gender according to cisnormative pressures, GICE has also been a component of sexual orientation change efforts (SOCE). As intense focus on cisnormative conformity is a frequent characteristic of SOCE it is possible that authors in the literature describing sexual orientation change efforts misgendered their participants (Hipp et al., 2019). Moreover, "ex-gay" literature and discourse conceptualize gender diversity as a sin, a mental illness, and harmful, perpetuating cisgenderism and transmisogyny (Robinson & Spivey, 2019). Finally, Hipp et al. (2019) identified forms of GICE that are often not discussed in the psychological literature but that appear to disproportionately affect Black transgender and gender nonbinary individuals including violence, "church hurt" (i.e., religious or faith-based trauma), and gatekeeping from gender affirming care. These efforts may be referred to as "conversion therapies", "corrective" treatments, or "normalizing" therapies (Hill et al., 2010). However, to consider these techniques as therapies or treatments is inaccurate and inappropriate because, the incongruence between sex and gender in and of itself is not a mental disorder (World Health Organization, n.d.) so, any behavioral health or GICE technique or treatment that seeks to change an individual's gender identity or expression is not indicated; thus, any behavioral health or GICE effort that attempt to change an individual's gender identity or expression is inappropriate (Hill et al. 2010; SAMHSA, 2015).

With roots in this history, GICE are founded on the notion that any gender identity that is not concordant with sex assigned at birth is disordered, and that a cisgender identity is healthier, preferable, and superior to a transgender or gender nonbinary identity (Ansara & Hegarty, 2011; Hill et al., 2010; Robinson & Spivey, 2019).

GICE cause harm by reinforcing anti-transgender and anti-gender nonbinary stigma and discrimination (Turban et al., 2020); and by creating social pressure on an individual to conform to an

identity and/or presentation that may not be consistent with their sense of self (e.g., Bockting et al., 2013; Egan & Perry, 2001; Meyer, 2003; Nadal et al., 2012; Russell et al., 2012; Toomey et al., 2010; Sandfort et al., 2007). Furthermore, GICE are not supported by empirical evidence as effective practices for changing gender identity and are associated with psychological and social harm (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006). The American Psychological Association (APA), as well as other healthcare organizations, (e.g., American Counseling Association, World Professional Association for Transgender Health) have established empirically-supported practice guidelines that encourage clinicians to use gender-affirming practices when addressing gender identity issues (ACA, 2010; APA, 2015; Coleman et al., 2012). Additionally, a number of national and international professional healthcare organizations have publicly warned against the harmful effects of GICE and SOCE (Sexual Orientation Change Efforts) by endorsing the United States Joint Statement Against Conversion Efforts (USJS, n.d.), including the American Academy of Family Physicians, American Academy of Nursing, American Association of Sexual Educators, Counselors and Therapists, American Counseling Association, American Medical Association, American Medical Student Association, American Psychoanalytic Association, The Association of LGBTQ Psychiatrists, Society for Affectional, Intersex, and Gender Expansive Identities, Clinical Social Work Association, GLMA: Health Professionals Advancing LGBTQ Equality, The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies, and the World Professional Association for Transgender Health. A growing number of states and municipalities have enacted laws that prohibit licensed mental health professionals from engaging in sexual orientation and gender identity change efforts with minors (Movement Advancement Project, n.d.)

GENDER DIVERSITY, STIGMA, AND DISCRIMINATION

WHEREAS diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder (APA, 2009, 2015; SAMHSA, 2015);

WHEREAS gender diverse individuals experience cissexist discrimination and prejudice throughout the lifespan and life domains (APA, 2009) including significant discrimination in healthcare settings (Burnes et al., 2016; Fredriksen-Goldsen et al., 2014; Grant et al., 2011; James et al., 2016; Johns et al, 2019; Lambda Legal, 2010; Macapagal et al., 2016; Reisner et al., 2015; White Hughto et al., 2015);

WHEREAS the practice of GICE reinforces stigma and discrimination against transgender and gender diverse people (Turban et al., 2020);

WHEREAS gender-related bias, victimization, discrimination, criminalization, and forced-gender conformity experienced by transgender and gender nonbinary people are associated with poor psychosocial outcomes, such as heightened psychological distress, compromised overall wellbeing, and disparities across various contexts (e.g., healthcare, schools/education, workplace, law) (Bockting et al., 2013; dickey et al., 2016; Egan & Perry, 2001; Meyer, 2003; Nadal et al., 2012; Russell et al., 2012; Hendricks & Testa, 2012; Toomey et al., 2010; Sandfort et al., 2007);

WHEREAS invalidation and rejection of transgender and gender nonbinary identities and diverse gender expressions by others (e.g., families, therapists, school personnel) are forms of discrimination, stigma, and victimization, which result in psychological distress (Bockting et al., 2013; D'Augelli et al., 2006; Egan & Perry, 2001; Hendricks & Testa, 2012; Hidalgo et al., 2015; Landolt et al., 2004; Meyer, 2003; Nadal et al., 2012; Price, et al., 2019; Roberts et al., 2012; Sandfort et al., 2007; Stotzer, 2012; Russell et al., 2012; Toomey et al., 2010; Truong et al., 2020a, 2020b; Zongrone et al., 2020);

GICE AND RISKS OF HARM

WHEREAS individuals who have experienced pressure or coercion to conform to their sex assigned at birth or therapy that was biased toward conformity to one's assigned sex at birth have reported harm resulting from these experience such as emotional distress, loss of relationships, and low self-worth (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006);

WHEREAS in one study of a large online sample of LGBTQ young people, those who reported experiencing change efforts were more than twice as likely to report having attempted suicide and having multiple suicide attempts as those who did not experience change efforts, (Green et al., 2020);

WHEREAS GICE have not been shown to alleviate or resolve gender dysphoria (Bradley & Zucker, 1997; Cohen-Kettenis & Kuiper, 1984; Gelder & Marks, 1969; Greenson, 1964; Pauly, 1965, SAMHSA, 2015);

WHEREAS GICE can cause undue stress and suffering and interfere with healthy sexual and gender identity development (Hiestand & Levitt, 2005; SAMHSA, 2015);

WHEREAS GICE can reduce one's willingness to pursue future mental health treatment (Craig et al., 2017);

WHEREAS GICE often involves the promotion of stereotyped gender behaviors consistent with cultural expectations (Coleman et al., 2012; Hill et al., 2010);

WHEREAS GICE are associated with harmful social and emotional effects for many individuals, including but not limited to, the onset or increase of depression, anxiety, suicidality, loss of sexual feeling, impotence, deteriorated family relationships, a range of post-traumatic responses, and substance abuse (c.f. Burnes et al., 2016; Green et al., 2020; SAMHSA 2015 for a review; Turban et al., 2019);

WHEREAS diverse gender expressions and transgender and gender nonbinary identities are not mental disorders (American Psychiatric Association, 2013) and many transgender and gender nonbinary individuals lead satisfying lives and have healthy relationships (APA, 2015; SAMHSA, 2015);

GENDER AFFIRMING PRACTICES

WHEREAS transgender and gender nonbinary people whose gender has been affirmed report increased quality of life (Ainsworth & Spiegel, 2010; APA, 2015; Gerhardstein & Anderson, 2010; Kraemer et al., 2008; Newfield et al., 2006);

WHEREAS self-determination in defining one's gender identity is a source of resilience for transgender and gender nonbinary people and associated with improvements in wellbeing and reductions in psychological distress (Menvielle & Tuerk, 2002; Pickstone-Taylor, 2003; Rosenburg, 2002; Singh et al., 2011; Singh et al., 2014);

WHEREAS individuals who have experienced gender-affirming psychological and medical practices report improved psychological functioning, quality of life, treatment retention and engagement, and reductions in psychological distress, gender dysphoria, and maladaptive coping mechanisms (Austin & Craig, 2015; de Vries et al., 2014; Haas et al., 2011; Sevelius, 2013; White Hughto & Reisner, 2016);

WHEREAS professional consensus recommends affirming therapeutic interventions for transgender and gender nonbinary adults who request that a therapist engage in GICE, and for trans youth whose parents/guardians or other custodians (e.g., state, foster care) request that a therapist engage in GICE (American Counseling Association, 2009; APA, 2012; 2015; American Psychiatric Association, 2018; Byne et al., 2012; Edwards-Leeper et al., 2016);

WHEREAS affirming therapeutic practices and guidelines recommend that the therapist should remain objective and nonjudgmental to the outcome, focusing on empowering the client to be active in exploring, discovering, and understanding their own identity (American Counseling Association, 2009; APA, 2012; 2015; American Psychiatric Association, 2018; Byne et al., 2012; Edwards-Leeper et al., 2016);

APA POLICY

WHEREAS APA opposes discrimination on the basis of gender identity, gender expression, and transgender and gender nonbinary identities, and actively opposes the adoption of discriminatory legislation (APA, 2008);

WHEREAS APA supports the passage of laws and policies protecting the legal rights and freedoms of transgender and gender nonbinary people, regardless of gender identity or expression (APA, 2008);

WHEREAS Psychologists' work is based upon established scientific and professional knowledge of the discipline. (APA, 2017b, p. 5);

WHEREAS APA recognizes that psychologists work is based upon Respect for People's Rights and Dignity (Principle E), Avoiding Harm (3.04), and Unfair Discrimination (3.01; APA, 2017b);

WHEREAS gender affirming psychotherapy is founded in clinical practice guidelines, and harm has not been identified for any of these gender-affirming treatment practices (APA, 2015, 2017b; Byne et al., 2012);

WHEREAS the APA policy and practice guidelines (e.g., Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality; Guidelines for Psychological Practice with Transgender and Gender Nonconforming People) affirm that psychologists do not engage in discriminatory or biased practices and urge psychologists to take a leadership role in preventing discrimination towards transgender and gender diverse people (APA, 2009, 2015, 2017a);

WHEREAS APA's 2005 Policy Statement on Evidence-Based Practice in Psychology defines evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture**,** and preferences (APA, 2005);

BE IT THEREFORE RESOLVED that consistent with the APA definition of evidence-based practice (APA, 2005), the APA affirms that scientific evidence and clinical experience indicate that GICE put individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid GICE;

BE IT FURTHER RESOLVED that APA opposes the idea that incongruence between sex and gender is a mental disorder (Hill et al., 2010; SAMHSA, 2015; WHO).

BE IT FURTHER RESOLVED that after reviewing scientific evidence on GICE harm, affirmative treatments, and professional practice guidelines, the APA affirms GICE are associated with reported harm.

BE IT FURTHER RESOLVED that the APA opposes GICE because of their association with harm.

BE IT FURTHER RESOLVED that Transgender and gender nonbinary identities, as well as other gender identities that transcend culturally prescriptive binary notions of gender, represent normal variations in human expression of gender.

BE IT FURTHER RESOLVEDthat neither transgender or gender nonbinary identities nor the pursuit of gender-affirming medical care constitutes evidence of a mental disorder.

BE IT FURTHER RESOLVED that APA opposes portrayals of transgender and gender nonbinary people as mentally ill because of their gender identities and expressions.

BE IT FURTHER RESOLVED that evidence supports psychologists in their professional roles to use affirming and culturally relevant approaches with individuals of diverse gender expressions and identities.

BE IT FURTHER RESOLVED that APA is committed to promoting accurate scientific data regarding gender identity and expression in its own policy, public advocacy, judicial proceedings, media, and public opinion;

BE IT FURTHER RESOLVED that APA encourages collaboration between and among individuals and organizations to promote the wellbeing of transgender and gender nonbinary people;

BE IT FURTHER RESOLVED that the APA encourages psychologists to be aware of multiple and intersecting factors in identity, such as sex assigned at birth, gender expression, gender identity, age, race, ethnicity, religion, spirituality, socioeconomic status, disability, national origin, and sexual orientation in conceptualization, treatment, research, and teaching about transgender and gender nonbinary people;

BE IT FURTHER RESOLVED that the APA opposes the dissemination of inaccurate information about gender identity, gender expression, and the efficacy of GICE, including the claim that gender identity can be changed through treatment, the characterization of transgender or gender nonbinary identity as a mental disorder and the promotion of treatments that prescribe gender identity or expression consistent with one's birth-assigned sex as effective for clients with gender dysphoria;

BE IT FURTHER RESOLVED that APA encourages the development and dissemination of evidence-based, multiculturally-informed, and gender affirmative educational resources that inform psychologists, the community and education and mental health institutions about the harms of GICE;

BE IT FURTHER RESOLVED that APA re-affirms that APA (2015) encourages psychologists to:

- Acknowledge the diversity and complexity of identities and experiences and recognize transgender and gender nonbinary identities as healthy expressions of gender
- Recognize that descriptions of any gender identity or expression as unnatural, abhorrent, or unhealthy perpetuate stigma for sexual and gender minorities, and have negative mental health and social consequences
- Assist clients in a developmentally appropriate manner to explore and understand the cultural and familial influence on gender roles and expression. Psychologists are urged to help clients in a developmentally appropriate manner understand the societal contexts of sexism, heterosexism, transphobia, racism and other forms of social oppression, and to use a developmental multicultural- and gender-affirmative framework in research, teaching, training, and supervision;

BE IT FURTHER RESOLVED that the American Psychological Association opposes GICE because there is evidence of former participants reporting harm resulting from their experiences of GICE and the contribution that such efforts make to social stigma, injustice, and prejudice directed at gender diverse individuals, consistent with other major professional mental health associations, including the American Psychiatric Association (2018); American Counseling Association (2017), SAMHSA (2015), American Academy of Child & Adolescent Psychiatry (2018), World Health Organization (n.d.) and World Psychiatric Association (2016);

BE IT FURTHER RESOLVED that the APA, because of evidence of harm and lack of evidence of efficacy, supports public policies and legislation that prohibit, or aim to reduce GICE, cissexism, and anti-transgender and anti-gender nonbinary bias and that increase support for gender diversity;

BE IT FURTHER RESOLVED that the APA supports collaboration and partnerships with global, national and state and local partners to achieve the aims of this resolution;

BE IT FURTHER RESOLVED that the APA promotes professional training in gender-affirming practices and opposes professional training in GICE in any stage of the education of psychologists, including graduate training, continuing education, and professional development.

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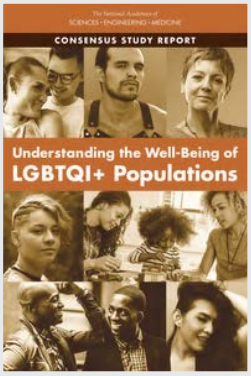
EXHIBIT G

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)



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Understanding the Well-Being of LGBTQI+ Populations

Committee on Understanding the Well-Being of Sexual and Gender Diverse Populations

Charlotte J. Patterson, Martín-José Sepúlveda, and Jordyn White, *Editors*

Committee on Population

Division of Behavioral and Social Sciences and Education

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Guidelines and Policies Related to Gender Affirmation

Clinicians who provide gender-affirming psychosocial and medical services in the United States are informed by expert evidence-based guidelines. In 2012, the World Professional Association for Transgender Health (WPATH) published version 7 of the *Standards of Care for the Health of Transgender, Transsexual, and Gender-Nonconforming People*, which have been continuously maintained since 1979, and revisions for version 8 are currently underway (Coleman et al., 2012). Two newer guidelines have also been published by the Endocrine Society (Hembree et al., 2017) and the Center of Excellence for Transgender Health (UCSF Transgender Care, 2016). Each set of guidelines is informed by the best available data and is intended to be flexible and holistic in application to individual people. All of the guidelines recommend psychosocial support in tandem with physical interventions and suggest timing interventions to optimize an individual's ability to give informed consent. Mental and physical health problems need not be resolved before a person can begin a process of medical gender affirmation, but they should be managed sufficiently such that they do not interfere with treatment.

A major success of these guidelines has been identifying evidence and establishing expert consensus that gender-affirming care is medically necessary and, further, that withholding this care is not a neutral option (World Professional Association for Transgender Health, 2016). A number of professional medical organizations have joined WPATH in recognizing that gender-affirming care is medically necessary for transgender people because it reduces distress and promotes well-being, while withholding care increases distress and decreases well-being (AMA, 2008; American Psychiatric Association, 2018; American Psychological Association (APA), 2008, 2015; American Academy of Family Physicians, 2012; American Academy of Pediatrics, 2018; American College of Nurse Midwives, 2012; American College of Obstetricians and Gynecologists, 2011; Endocrine Society, 2017). Accordingly, public and private insurers have expanded access to gender-affirming care; some have done so proactively, while others have been required by state and federal nondiscrimination laws to remove coverage exclusions (Baker, 2017).

Coverage requirements for gender-affirming care typically rely on an overarching principle of parity between medically necessary services for transgender and cisgender people. Treatments that are gender-affirming for transgender patients are covered by public and private insurers for intersex and cisgender people for a variety of conditions, including genital difference, endocrine disorders, cancer prevention or treatment, and reconstructive surgeries following an injury. Examples of these services include testosterone or estrogen replacement therapy after surgery or menopause, vaginoplasty after pelvic surgery or for women with vaginal agenesis in the context of an intersex condition, and phalloplasty for cisgender male service members injured in war (Spade et al., 2009; Baker et al., 2012; Balzano and Hudak, 2018).

As this report goes to press, 24 states and the District of Columbia have enacted laws or made administrative changes prohibiting transgender-specific insurance exclusions in private coverage (Movement Advancement Project, 2020a). However, Medicaid programs in 10 states continue to explicitly exclude gender-affirming care for transgender individuals, and many states do not address the issue of this coverage in Medicaid (Mallory and Tentindo, 2019). At the federal level, the Medicare program removed its exclusion for "transsexual surgery" in 2014 (U.S. Department of Health and Human Services, 2014), though coverage decisions related to gender-affirming surgeries are still made on a case-by-case basis (CMS, 2016). As discussed

European samples, a United States-based comprehensive registry that tracks patient-centered outcomes for both youth and adults could lead to valuable insights on the benefits of medically supervised gender affirmation (Kimberly et al., 2018). Much remains to be learned regarding optimal timing and risk profiles for surgeries and other medical interventions, aided by standardized and validated tools for body satisfaction, gender-related quality of life, gender dysphoria, and mental health (Olson et al., 2016). Standardized assessment and reporting of outcomes are particularly essential for helping clinicians and patients understand surgical options. In this area, too, more attention is needed to populations that tend to be invisible or underrepresented in clinical research, especially transgender people of color and non-binary individuals. Very little is known about the experiences and options for treatment for transgender individuals with intersex traits, especially those who had irreversible treatments as children. Overall, however, the evidence indicates that gender-affirming interventions, including social affirmation, hormonal treatment, and surgeries, are medically necessary for reducing distress and improving the health and well-being of transgender people.

CONVERSION THERAPY

Efforts to change sexual orientation or gender identity, which initially gained traction in the 1960s and which are often referred to as conversion or reparative therapies, assume that non-cisgender and non-heterosexual identities are abnormal. In 2009 the American Psychological Association (APA) produced a landmark report that systematically reviewed the evidence of efficacy for sexual orientation change efforts (APA, 2009). Most of this research was conducted prior to 1981, and very few studies were experimental in design. The task force found that some people sought sexual orientation change efforts due to distress over their sexual orientation but that the treatments were unable to reduce same-sex attractions or increase other-sex attractions. Furthermore, there was evidence that individuals experienced harm from these treatments, including sexual dysfunction, depression, anxiety, and suicidality. With regard to gender identity, while interest in the so-called “desistence” of transgender identity has been informed by studies suggesting that as high as 80 percent of prepubertal youth presenting to pediatric gender clinics ultimately do not identify as transgender, many of the youth included in these studies did not meet full DSM criteria for a gender incongruence diagnosis (Olson, 2009). Recent evidence supports that early social affirmation of transgender identity is associated with good outcomes (Olson et al., 2016; Durwood, McLaughlin, and Olson, 2017) and that lack of social affirmation correlates with depression, anxiety, and suicidality (de Vries et al., 2016; James et al., 2016).

Consequently, sexual orientation and gender identity conversion efforts have fallen out of favor in mainstream psychological and psychiatric practice. By the time of the 2011 Institute of Medicine report, many medical organizations had issued statements condemning sexual orientation change efforts based on the lack of efficacy and evidence of harm. Many of these organizations have since updated their positions to decry conversion therapy for both sexual orientation and gender identity (Streed et al., 2019a; SAMHSA, 2015; Rafferty et al., 2018; American Academy of Child and Adolescent Psychiatry, 2018; AMA and GLMA, 2018).

However, there is recent evidence that LGBTQ youth and adults continue to be exposed to conversion therapy. A 2019 report from the Williams Institute estimated that 698,000 adults between ages 18 and 59 have undergone conversion therapy from a licensed professional or religious advisor, of whom 350,000 were adolescents when treated (Mallory, Brown, and Conron, 2015). The same study estimated than additional 57,000 youth will receive conversion

therapy from a health care or religious provider before 18 years of age. Among 25,000 LGBTQ youth respondents to a 2019 national survey, 67 percent reported that someone attempted to convince them to change their gender identity or sexual orientation (Trevor Project, 2019). A survey of 762 marriage and family therapists and members of the American Academy of Marriage and Family Therapists, which has a position statement against conversion therapy, found that 19.4 percent of respondents believed it was ethical to practice sexual orientation change therapy, and 3.5 percent of respondents had done so. This belief was associated with higher levels of negative beliefs about LGB clients than those of other therapists (McGeorge, Carlson, and Toomey, 2015).

A recent survey was among the first to evaluate the link between sexual orientation change therapy and the health of young people: among 245 white and Latinx LGBT individuals between the ages of 21 and 25, exposure to conversion efforts within or outside of their families during adolescence was associated with higher family religiosity, lower family socioeconomic status, and higher individual gender nonconformity (Ryan et al., 2018). In addition, exposure to conversion efforts during adolescence was significantly associated with increased suicidal ideation, suicide attempts, and depression, as well as diminished life satisfaction, self-esteem, social support, educational attainment, and lower income in young adulthood.

A systematic narrative review of gender identity conversion efforts found few data and a notable absence of research about their effects on both adolescents and adults (Wright, Candy, and King, 2018). However, a recent study using data from the 2015 USTS found that 14 percent of respondents had been exposed to gender identity conversion therapy during their lifetimes; exposure was associated with significantly higher rates of past-month severe psychological distress and lifetime suicide attempts compared with respondents who had not been exposed to such therapy (Turban et al., 2019). Exposure to gender identity conversion therapy before age 10 was associated with nearly twice the rate of lifetime suicide attempts.

The available evidence suggests that sexual orientation and gender identity conversion efforts are ineffective and dangerously detrimental to the health of SGD populations, especially for minors who are unable to give informed consent. As of early 2020, 20 states, the District of Columbia, Puerto Rico, and a number of municipalities had outlawed sexual orientation and gender identity conversion therapy for minors (Movement Advancement Project, 2020d). As growing numbers of professional organizations and governments call for or legislate an end to conversion therapy, particularly for minors, it is important for clinicians working with SGD populations to understand the effects that these experiences can have on individuals, even many years later. Research on strategies for helping individuals who have experienced conversion therapy to heal and recover is essential. In order to end the practice of conversion therapy, it is not sufficient for professional organizations to recommend against conversion therapy; rather, professionals may require dedicated and specific training on the inefficacy and danger of conversion treatments, and insurance providers should consider limiting coverage for these non-evidence-based practices.

INTERSEX GENITAL SURGERY

The most expansive estimations of the prevalence of intersex traits, including any variation in any marker of sex (chromosomes, internal reproductive anatomy, external genital shape, and secondary sex traits) concludes that up to 1.7 percent of the population has an intersex trait (Fausto-Sterling, 2000). Estimates based on the number of people with clinically identifiable

EXHIBIT H

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Journal Pre-proof

Do Clinical Data From Transgender Adolescents Support the Phenomenon of "Rapid-Onset Gender Dysphoria"?

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Title: **Do Clinical Data From Transgender Adolescents Support the Phenomenon of "Rapid-Onset Gender Dysphoria"?**

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Abbreviations: ; OASIS = Overall Anxiety Severity and Impairment Scale; MDS = Modified Depression Scale; K6 = Kessler-6 Scale; TYC-GDS = Trans Youth CAN! Gender Distress Scale

Although emergence of gender dysphoria at puberty is long established, a distinct pathway of "rapid onset gender dysphoria" (ROGD) was recently hypothesized based on parental data. Using adolescent clinical data, we tested a series of associations that would be consistent with this pathway, however our results did not support the ROGD hypothesis.

Puberty has long been understood as one period when gender dysphoria often first emerges.(1) Although most transgender (trans) older adolescents and adults report needing gender-affirming medical care (hormones and/or surgeries), and also report having been aware of their gender at young ages,(2) only a small proportion receive gender-affirming care as adolescents. Use of hormonal suppression with a gonadotropic-releasing hormone agonist (GnRHa), and hormones such as estrogen and testosterone therapies in trans and gender-diverse adolescents is supported by the American Academy of Pediatrics, the Pediatric Endocrine Society, the Endocrine Society, and the World Professional Association for Transgender Health.(1,3–5) Referrals to adolescent gender clinics have increased internationally, particularly among those assigned female at birth.(6–9)

In 2018, a phenomenon of "rapid onset gender dysphoria" or "ROGD" was hypothesized as a distinct pathway involving social contagion among youth vulnerable due to mental or neurodevelopmental disorders,(10–12) raising public concerns regarding potential for later regret following gender-affirming medical care. This discussion has occurred primarily in the context of data from a single online parental survey.(10,11) Although this parental study has generated controversy,(13) methodological and social critique,(12,14,15) and calls for additional research,(16,17) its hypotheses have not yet been tested on data from youth themselves. Specifically, ROGD is hypothesized as a phenomenon in youth with gender dysphoria emerging

at or after puberty, socially influenced through peer contagion, and with contributing factors including poor mental health, neurodevelopmental disabilities, parent-child conflict, and maladaptive coping strategies.(10,11)

If the "ROGD" hypothesis indeed characterizes a distinct clinical phenomenon, and these youth access referrals for hormone suppression or gender-affirming hormones, then we would expect to see differentiation within clinical samples between those with more-recent (ie, "rapid-onset") vs. more-remote knowledge regarding their gender. Based on the published hypothesis,(10) we would expect more recent gender knowledge to be associated with self-reported mental health measures, mental health and neurodevelopmental disability diagnoses, behaviors consistent with maladaptive coping (e.g. self-harm), support from online and/or transgender friends but not parents, and lesser gender dysphoria. We aim to test these hypotheses.

Methods

Baseline data (2017–2019) from the Trans Youth CAN! Cohort included pubertal/postpubertal adolescents aged <16 attending a first referral visit for hormone suppression or gender-affirming hormones at 10 Canadian medical clinics that provide specialized gender-affirming care to adolescents through a range of different care models. Ethics approval was received from all study sites. Years gender was known was missing for one participant (excluded), for a final sample of n=173. Methods and measures are described in detail elsewhere.(18)

Self-reported measures were obtained from baseline interviewer-administered adolescent surveys,(19) and diagnoses from baseline clinical records.(20) *Recent gender knowledge* was

coded by subtracting age in years from age adolescents self-reported they "realized your gender was different from what other people called you". As ages were whole numbers, a difference of 1 could indicate <1 year to just under 2 years. Values ≤1 were coded as recent gender knowledge, with an alternate definition (values ≤2) for sensitivity analysis. *Mental health symptoms* were assessed with the Overall Anxiety Severity and Impairment Scale (OASIS),(21) the Modified Depression Scale (MDS),(22) and the Kessler-6 (K6) scale for psychological distress.(23) *Mental health diagnoses* extracted from chart included anxiety, depression, personality disorder, eating disorder, and *neurodevelopmental disorder diagnoses* included autism, obsessive compulsive disorder, or attention deficit hyperactivity disorder. *Gender dysphoria symptoms* were assessed using the Trans Youth CAN! Gender Distress Scale (TYC-GDS).(24) Self-reported *mental health behaviors* included self-harm, substance use, and suicidal behavior. Three measures captured *social connections* to online and trans communities: having gender-supportive online friends was coded if adolescents reported online friends who knew their gender and were "very supportive", and having online or trans friends as general sources of support was indicated in checklist items. *Parental support* was coded if youth indicated all biological/step/foster parents were "very supportive" of their gender identity or expression.

Statistical analyses were conducted using SAS version 9.4.1, weighted to account for clinics' different recruitment periods due to staggered start dates, to improve generalizability.(18) For analyses of associations between recency of gender knowledge and hypothesized correlates, a series of multiple regressions was conducted, with recency as the independent variable of interest, controlling for age and sex assigned at birth. Linear regressions were used for continuous dependent variables (e.g., psychometric scales). For dichotomous dependent variables, modified Poisson regression with robust variance estimation was used.(25)

As "rapid-onset" has not been precisely defined, we conducted a sensitivity analysis repeating these analyses using the alternate (value ≤2) definition of recent gender knowledge.

Results

Recency of gender knowledge is presented in the Figure, results of hypothesized associations (recency value ≤1) in Table I, and variable means and frequencies in Table II (available at www.jpeds.com). Controlling for age and sex assigned at birth, recent gender knowledge was not significantly associated with depressive symptoms, psychological distress, past diagnoses with mental health issues or neurodevelopmental disorders, gender dysphoria symptoms, self-harm, past-year suicide attempt, having gender-supportive online friends, general support from online friends or transgender friends, or gender support from parents. Recent gender knowledge was associated with lower scores on anxiety severity/impairment (b= −3.272; 95% CI: −5.172, −1.373), and lower prevalence of marijuana use (PR=0.11; 95% CI: 0.02, 0.82), counter to hypothesized directions of effect. For sensitivity analysis using the alternate (value ≤2) definition of recent gender knowledge, we found all results substantively the same in statistical significance and direction of effect, except past-year marijuana use, which now only approached statistical significance (p=0.0677).

Discussion

We did not find support within a clinical population for a new etiologic phenomenon of "ROGD" during adolescence. Among adolescents under age 16 seen in specialized gender clinics, associations between more recent gender knowledge and factors hypothesized to be involved in ROGD were either not statistically significant, or were in the opposite direction to

what would be hypothesized. This putative phenomenon was posited based on survey data from a convenience sample of parents recruited from websites,(10) and may represent the perceptions or experiences of those parents, rather than of adolescents, particularly those who may enter into clinical care. Similar analyses should be replicated using additional clinical and community data sources. Our finding of lower anxiety severity/impairment scores in adolescents with more recent gender knowledge suggests the potential for longstanding experiences of gender dysphoria (or their social complications) playing a role in development of anxiety, which could also be explored in future research.

Acknowledgment: The Trans Youth CAN! Study Team thank the trans youth and their families who have generously shared their time and experience with us. We acknowledge the contributions of the local site teams to participant recruitment, in particular the team of research assistants involved in data collection.

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Figure 1. Recency of gender knowledge among adolescents age <16 referred to Canadian clinics for hormone suppression or gender-affirming hormones (n=173). Age at which knew gender was different was subtracted from current age in years; thus, "2 years" could range from more than 1 year to less than 3 years. Lighter gray represents recent gender knowledge in this analysis, with a sensitivity analysis also including the patterned bar.

Table 1. Associations between short-term awareness of gender and variables hypothesized to be associated with "rapid-onset gender dysphoria," controlling for age and sex assigned at birth

Dependent variable	B [a]	SE	p	PR [a]	95% CI [b]
Mental health scales					
Anxiety severity/impairment (OASIS)	-3.272	0.961	0.0008		(-5.172 -1.373)
Depressive symptoms (MDS)	-1.276	0.845	0.1328		(-2.944, 0.392)
Psychological distress (K6)	-1.156	1.060	0.2771		(-3.248, 0.936)
Record of diagnosis with mental health disorder [c]	-0.509	0.315	0.1059	0.60	(0.32, 1.11)
Record of diagnosis with neurodevelopmental disorder [d]	0.066	0.362	0.8563	1.07	(0.52, 2.17)
Gender dysphoria/distress (TYC-GDS)	-0.193	0.122	0.1139		(-0.434, 0.047)
Mental health related behaviors					
Self harm, past year	-0.052	0.191	0.7833	0.95	(0.65, 1.38)
Marijuana use, past year	-2.178	1.010	0.0310	0.11	(0.02, 0.82)
Past-year suicide attempt	-0.592	0.785	0.4505	0.55	(0.12, 2.58)
Social connection indicators [e]					
Reports having online friends supportive of gender	-0.050	0.157	0.7505	0.95	(0.70, 1.29)

Indicates online friends as source of general support	-0.223	0.286	0.4366	0.80	(0.46, 1.40)
Indicates trans friends as source of general support	-0.049	0.298	0.1016	0.61	(0.34, 1.10)
All parents supportive of gender identity/expression	-0.004	0.202	0.9836	1.00	(0.67, 1.48)

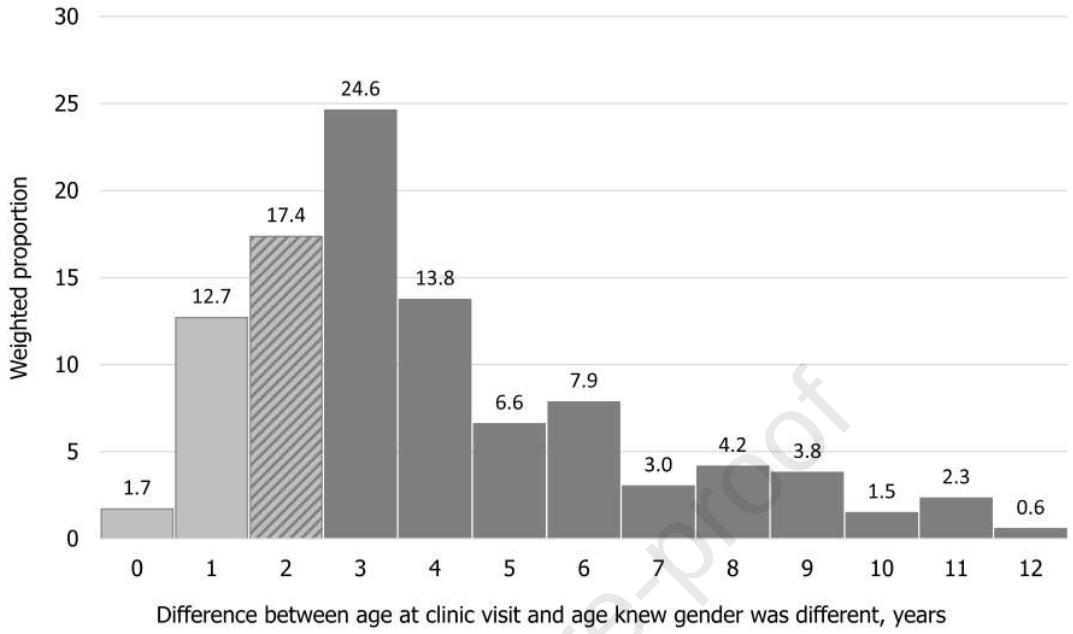
a. Estimates adjusted for age in years and sex assigned at birth. B = beta, regression parameter estimate; PR = prevalence ratio.

b. 95% confidence intervals for betas (for linear regressions) or PRRs (for modified Poisson regressions)

c. Extracted from medical record: any diagnosis from clinic or referrer of anxiety, depression, personality disorder, eating disorder. Personality disorder diagnoses were uncommon (n=2) and no youth had a record of eating disorder diagnosis.

d. Extracted from medical record: any diagnosis from clinic or referrer of attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), or autism.

e. Hypothesized by other authors based on a survey of parents recruited from websites generally unsupportive of gender-affirming care.(10)



Appendix

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Online content to accompany the following Brief Report:

Bauer GR, Lawson ML, Metzger DL, for the Trans Youth CAN! Research Team. Do clinical data from transgender adolescents support the phenomenon of "rapid-onset gender dysphoria"? *Journal of Pediatrics*, 2021.

Online Table 2.
Weighted frequencies or means for sociodemographic and study variables (n=173)

Variable	Value
Age, n (%$_w$)	
10–11 years	17 (8.5)
12-13 years	37 (22.6)
14–15 years	119 (68.9)
Ethnoracial background,[a] , n (%$_w$)	
Indigenous	33 (18.4)
Non-Indigenous visible minority [b]	10 (6.6)
Non-Indigenous white	128 (75.0)
Immigration background, n (%$_w$)	
1 or more immigrant parent	126 (28.7)
No immigrant parents	44 (71.3)
Living environment, n (%$_w$)	
City	87 (55.2)
Suburb	59 (33.9)
Rural	27 (10.9)
Gender identity, n (%$_w$)	
Male or primarily a boy	125 (75.7)
Female or primarily a girl	32 (15.9)
Non-binary [c]	14 (8.3)
Mental health scales, mean$_w$ (SD)	
Anxiety severity/impairment (OASIS)	8.842 (4.548)
Depressive symptoms (MDS)	15.077 (4.030)
Psychological distress (K6)	10.746 (5.100)
Record of diagnosis with mental health disorder,[d] n (%$_w$)	92 (51.6)
Record of diagnosis with neurodevelopmental disorder,[e] , n (%$_w$)	44 (25.9)
Gender dysphoria/distress (TYC-GDS), mean$_w$ (SD)	4.048 (0.557)
Mental health related behaviors, n (%$_w$)	
Self harm, past year	110 (67.9)
Marijuana use, past year	29 (20.0)
Past-year suicide attempt	24 (16.9)
Social connection indicators,[f] n (%$_w$)	
Reports having online friends supportive of gender	109 (69.9)
Indicates online friends as source of general support	79 (49.3)
Indicates trans friends as source of general support	92 (55.8)
All parents supportive of gender identity/expression	109 (61.8)

a. Coded to match Statistics Canada categories of Indigenous, visible minority, and white. Non-white, Non-Indigenous ethnoracial backgrounds were indicated by the following numbers of participants: 6 Black Canadian or African-American, 2 Black African, 4 Latin American, 4 East Asian, 1 Indo-Caribbean, 3 Black Caribbean, 1 Middle Eastern, and 1 Southeast Asian (participants could indicate more than one).
b. The Canadian government defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour".(1)
c. Response option was "non-binary or something other than male or female".
d. Extracted from medical record: any diagnosis from clinic or referrer of anxiety, depression, personality disorder, eating disorder. Personality disorder diagnoses were uncommon (n=2) and no youth had a record of eating disorder diagnosis.
e. Extracted from medical record: any diagnosis from clinic or referrer of attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), or autism.
f. Hypothesized by other authors based on a survey of parents.(2)

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EXHIBIT I

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

March 22, 2017

To Whom It May Concern,

Dr. Paul McHugh and Dr. Lawrence Mayer's Fall 2016 report, "Sexuality and Gender: New Findings from the Biological, Psychological and Social Sciences," published in the 50th issue of the non-peer reviewed bioethics magazine The New Atlantis, misleads readers about the state of scientific research and evidence-based clinical practice guidelines addressing the health of people who are lesbian, gay, bisexual, transgender and queer (LGBTQ).

As researchers with expertise in gender and sexuality, and/or as clinicians who serve LGBTQ people, we are called to correct the record. A substantial body of research points to stigma and its consequences as contributing to the mental and physical health disparities among LGBTQ people.[1-16] Based on scientific consensus, many major medical associations have issued guidelines and policy statements calling for clinicians to affirm and support the sexual orientation, gender identity and gender expression of their patients as part of a standard, evidence-based approach to high quality, patient-centered healthcare.[17-25]

Although the “Sexuality and Gender” report cites many peer-reviewed scientific articles, the interpretation, analysis, and summary of the scientific evidence in the report has not been peer-reviewed. As scientific and medical experts, we affirm that the report's conclusions do not reflect current scientific or medical consensus about sexual orientation or gender identity research findings or clinical care recommendations. As such, the report's conclusions should not be viewed as a source of scientific or medical justification to support any legislation, judicial action, policymaking or clinical decision-making affecting the lives of LGBTQ people or their families.

In summary, as researchers and clinicians with expertise in gender and sexuality, we affirm that the “Sexuality and Gender” report does not represent prevailing expert consensus opinion about sexual orientation or gender identity related research or clinical care.

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EXHIBIT J

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

OP-ED OPINION

Hopkins faculty disavow 'troubling' report on gender and sexuality

By CHRIS BEYRER, ROBERT W. BLUM and TONIA C. POTEAT
SEP 28, 2016 AT 10:55 AM

FEEDBACK

Respect is the cornerstone of university life: respect for speech and a diversity of views; respect for students, colleagues and patients; and respect for science, which is our lifeblood as an institution.

As faculty at Johns Hopkins, a major educational, research and health institution, we are writing to express our concern about a recently published report that we believe mischaracterizes the current state of the science on sexuality and gender.

Exhibit 0020

Science, and particularly the fields of psychiatry and psychology, has made major advances in our understanding of the complex issues of sexual orientation and gender identity. For instance, accumulating data support the concept that gender identity is not strictly a binary phenomenon. And scientific evidence clearly documents that sexual and romantic attractions to people of the same and/or different sexes are normal variations of the diversity of human sexuality.

Homosexuality is no longer considered an illness by the American Psychiatric Association, the American Psychological Association, the American Medical Association or any of the other mainstream professional organizations in the health field. These organizations have come to affirm what LGBTQ people and their loved ones have known for years: that being gay or transgender is perfectly consistent with being healthy and well.

Yet LGBTQ communities have been subject to discrimination, including in health care services. A 2011 landmark report by the Institute of Medicine (IOM) reviewed this history of maltreatment and affirmed that substantial health disparities exist for LGBTQ people, most often fueled by stigma, discrimination and homophobia. This key IOM report outlines an important research agenda in the field, and we are learning more each day about gender, gender identity, and transgender and gender-nonconforming people and their well-being — including best practices for gender-affirming services.

As faculty at Johns Hopkins, we are committed to serving the health needs of the LGBTQ community in a manner that is informed by the best available science — a manner that is respectful and inclusive and supports the rights of LGBTQ people to live full and open lives without fear of discrimination or bias based on their sexual orientation or gender identity.

That is why the recent report, released by one current and one former member of our faculty on the topic of LGBTQ health, is so troubling. The report, "Sexuality and Gender: Findings from the Biological and Psychological and Social Sciences," was not published in the scientific literature, where it would have been subject to rigorous peer review prior to publication. It purports to detail the science of this area, but it falls short of being a comprehensive review.

For instance, the report omits post-2010 work by Dr. Mark Hatzenbuehler of Columbia University and thereby underemphasizes the negative role that stigma and oppression play in LGBTQ mortality and health behaviors. It comes to different conclusions about complex questions such as the origins of homosexuality from those reached by a recent review of the scientific literature by psychologist Dr. J. Michael Bailey and colleagues, commissioned by the prestigious Association for Psychological Science. As now stated, the report's findings could further stigmatize and harm the health of LGBTQ communities, and the report is already being widely touted by organizations opposed to LGBTQ rights.

Because of the report, the Human Rights Campaign has warned Johns Hopkins that it is reviewing, and may remove from the institution, its high ranking in the HRC Healthcare Equality Index. The national benchmarking tool evaluates health care facilities' policies and practices related to equity and inclusion of their LGBTQ patients, visitors and employees.

We wish to make clear that there are many people at Hopkins who hold a profound and long-standing commitment to the health, wellness, well-being, and fair and non-stigmatizing treatment of LGBTQ people and communities. We do not believe that the "Sexuality and Gender" report cited above is a comprehensive portrayal of the current science, and we respectfully disassociate ourselves from its findings.

We also vigorously support the right to academic freedom and scientific disagreement and debate. Indeed, debates are the very basis of the scientific method. That same commitment to scientific debate means we must engage the dialogue in a circumstance such as this, and not stand silently by.

This summer's tragic events in Orlando reminded all of us of the virulence of the oppression of LGBTQ people. We stand with the LGBTQ community, and with their allies, for dignity, inclusion and the recognition that homophobia and transphobia have no place in our institutions. Respect requires no less from all of us.

LATEST OP-ED

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10:57 AM

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5:54 AM

The authors are all faculty at the Johns Hopkins Bloomberg School of Public Health. Dr. Chris Beyrer (cbeyrer1@jhu.edu) is the Desmond Tutu Professor of Public Health and Human Rights. Dr. Robert W. Blum (rblum@jhu.edu) is William S. Gates Sr. Professor and chair of the Department of Population, Family and Reproductive Health; he also served on the Institute of Medicine Committee on LGBT Health Issues and Research Gaps and Opportunities. Tonia C. Poteat (tpoteat@jhu.edu) is an assistant professor in the Departments of Epidemiology and International Health. The following Johns Hopkins faculty members also contributed to this article: Danielle German, David Holtgrave, David Jernigan, Michelle Kaufman, Joanne Rosen and Dr. Ron Valdiserri. The views expressed above are those of the authors and do not necessarily represent the views of the Johns Hopkins University.

Topics: Medical Research, Human Rights Campaign, Columbia University

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	Case No. 1:19-cv-00272-LCB-LPA

PLAINTIFFS' MOTION TO EXCLUDE EXPERT TESTIMONY OF DR. PATRICK W. LAPPERT

Pursuant to Federal Rules of Civil Procedure 26 and Federal Rules of Evidence 104, 403, and 702, and for the reasons set forth in the accompanying memorandum of law, Plaintiffs respectfully move this Court to exclude the expert testimony of Dr. Patrick W. Lappert, a disclosed expert of Defendants Dale Folwell, Dee Jones, and the North Carolina State Health Plan for Teachers and State Employees. A supporting memorandum of law is filed contemporaneously herewith.

Dated this 2nd of February, 2022.

Respectfully submitted,

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* Appearing by special appearance pursuant to L.R. 83.1(d).

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all registered users.

Dated: February 2, 2022

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